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ABSTRACT

This manual provides resource tools and strategies to enhance the suicide prevention capabilities of health professionals and the health care setting in which care is provided. In the first section, terms are defined and the suicide prevention triangle model is described. Applications of the model and good practices for suicide prevention in any health setting are discussed. A suicide outcome and flow chart for high risk people is presented and described, and stress variables and the suicide sequence are discussed. The second part of the book focuses on assessment. Several assessment methods are presented and reviewed, e.g., the Future Orientation Scale, the Satisfaction Scale, the Significant Loss Check List, the Rorschach Signs of Suicidal Intent and Lethality, and criteria for hospitalization of a high risk person. The third section is devoted to intervention and includes a suicide prevention plan, information on suicide prevention classes, suggestions for conducting a psychological autopsy in which health professionals review their observation of and feelings about the client/patient, a summary of self-destructive thinking patterns, and model follow-up letters to be used after discharge from active treatment. The fourth section provides resources for suicide prevention including: check lists of computer access terms for knowledge bases on suicide, forensic issues, preferred methods and rituals of self-injury, manifestations of depression by age groups, and information to release to the press; a guide to continuing education audio-visual aids; and a listing of other references. Finally, a discussion on suicide in persons under 25 and in the elderly is presented. (JAC)

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To the graduate students of the professional schools of psychology, and the participants of the suicide prevention workshops, whose reactions to the items contained in this handbook inspired the search for an overall model: a three pronged approach analogous to the fire prevention triangle.

SUICIDE PREVENTION TRIANGLE

Table of Contents

i	Title
ii	Copyright
iii	Dedication
iv-v	Table of contents
vi	illustrations
vii	Preface

I ORIENTATION

2	Special Terms
5	Suicide Prevention Triangle: Models and applications
9	Good Practices for Prevention
13	Suicide Outcome, and Flow Chart for High Risk People
17	The High Risk Life Cycle

II ASSESSMENT

19	Epidemiological Criteria of High Risk for Suicide
20	Assessment Scales by Other Authors
22	Overlapping Items in Assessment Scales
24	Clinical Criteria for Rating Lethality of Planning
28	Self Injury Incident Form Eliciting the Facts
29	Draw a Person Committing Suicide; a Projective Procedure
31	Future Orientation Scale by Ganzler
35	Rorschach Signs of Suicidal Intent and Lethality
37	The Satisfaction Scale; a Measure of the Wish to Live
39	The Significant Loss Check List
41	Base Rate Computation for any Health Setting
44	Personal Criteria for when Death is Preferable
45	Criteria for Hospitalization of a High Risk Person

III INTERVENTIONS

48	Minimal Lethal Doses of Common Prescriptions
----	--

SUICIDE PREVENTION TRIANGLE

- 50 The Suicide Prevention Plan
- 53 Suicide Prevention Classes
- 56 Suggestions for Conducting the Psychological autopsy
- 58 Letter Follow up for High Risk People and Examples
- 60 Degrees of Observation for Degrees of Acute Behavior
- 61 Self Destructive Thinking Patterns: Summary

IV RESOURCES

- 63 Check Lists
 - 63 Computer Access Terms to Knowledge Bases
 - 67 Forensic Issues for Health Professionals
 - 68 Last Things Documenting a Concern About Death
 - 69 Optimal Information for Release to Media
 - 70 Preferred Self Injury Methods in U S
 - 71 Self Injury Rituals and Practices
 - 73 Manifestations of Depression by Age
- 75 Guide to Continuing Education Audio-Visual Aids
 - 76 1. Sound Cassettes
 - 77 2. Video Cassettes
 - 78 3. 16 mm Sound Movies
 - 79 4. Books Before 1938
 - 81 5. Books, 1938-1983
 - 86 6. Bibliographies, 1927-1980
- 87 References in this Workbook
- 94 Young suicide
- 100 Elderly Suicide
- 103 Quiz
- 106 Author photo & CV

v

SUICIDE PREVENTION TRIANGLE

List of Illustrations

Fronticepiece, Lucretia, Elizabetta Sirani, c 1635

Title page, Judas, woodcut, anon, 6th century

Opposite table of contents, Die Lebensmuden, F. Hodler, c 1900

1 I Orientation, Lucretia, J. del Conte, c1700

Opposite page 16 Flow chart, Cutter, 1982

18 II Assessment, Sophonisba, Mantegna, c. 1600

40 III Intervention, Ajax, anon. c 400 BC

54 IV Resources, Death Room, E. Munch, c1900 woodcut

Opposite References, Upstairs, G. Grosz, c 1922. engraving

Tailpiece, Encounter in Space, Edvard Munch, 1899. woodcut

O R I E N T A T I O N S



SUICIDE PREVENTION TRIANGLE

Preface

Little of the accumulated knowledge about suicide (Farberow, 1972; Miller, 1980), gets taught to licensed health professionals while they are in graduate school. One need only examine any textbook of abnormal psychology to observe the paucity of material. Catalogues of graduate or professional schools do not usually list courses in suicide and thanatology. Existing standards for suicide prevention are considered inadequate by the health professionals in the best position to judge (Berman & Cohen-Sandler, 1982).

With this background in mind, the Suicide Prevention Triangle brings an array of usable resource tools and strategies into one convenient format that will enhance suicide prevention capabilities of the health professional and the health setting in which care is delivered. These improvements over present practices can be achieved without extensive one on one supervision, thus making scarce professional time count. Massive medications, and unnecessary risk to the client can be avoided. The suggested practices do not represent increased professional time commitments, hardware nor other dollar costs.

The procedures described in this workbook require a high level of competence in at least one of the health care professions currently employed in all settings: hospital, clinics, health medical organizations, but especially private practice where the majority of high risk clients surface one to three months before suicidal behavior manifests first.

The models for preventing self injury behavior presented have the advantage of maximizing optimal care by motivating the client to cooperate in the prevention of their own self injuries. The use of the Fire Prevention Triangle as a model for suicide prevention is especially powerful since it brings to mind the notion of reducing the wish to die, block the preferred self injury method or palliating the distress that precipitate self destructive behavior.

In order for any prevention method to be effective the health professional must hold a passionate belief that suicide is bad for everybody, and therefore worthy of more optimal efforts to deter than is commonly observed today. This value must be experienced at a personal level such that it applies without exception, even to one's own personal right "to commit suicide" (Cutter, 1983).

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Special terms

The licensed health professionals using this workbook need to be aware of the different usages of the word suicide. These are:

1. The wish to die, or suicidal intent
2. The act of self injury, or suicide attempt
3. The vital outcome, life or death, or suicide commit

The three operations indicated above get blurred by the victims, the family and the health professional providing care. The distinctions given should be followed and emphasized in contacts with high risk people.

The wish to die is relatively universal, benign and much like any wish except for the social response it invokes. It is not monolithic. It varies in degree and duration, typically coming and going thru the life time of most people, but especially those whose distress is continuing or increasing.

The act of self injury varies in degree of lethality. Paradoxically there is no assurance that any one method will result in death

The vital outcome, death or continued life, is not predictable either by the victim nor the professional. Death can occur accidentally, with minimum lethality. Continued survival is also possible even with high lethality. The moment of death cannot be experienced, and for the victim has no operational meaning. The nearest familiarity is the process of interruption: going to sleep or losing consciousness, from which one usually awakens.

Psychological cessation is the mental equivalent of termination and refers to the goal sought by the wish to die. Death has different meanings for each person and often varies with the stage of life achieved. The victim's orientation toward imminent death is projective, in that personal meanings are assigned. However, most people usually include the notion that the current awareness will cease, or at least change.

Lethality refers to the degree of self damage achieved in the past acts of self injury, or likely to occur in a future episode. Lethality is independent of, and uncorrelated with the wish to die in that strong wishes may be present with methods that have little probability of damage. It is also unrelated to the risk of future attempts.

A person wishing to die now, is considered acute and requires immediate professional effort to deter an identified method of self injury.

After a victim is rescued or deterred from an attempt to achieve self injury, the person remains high risk for another episode over a long period measured in years.

Ambivalence describes the conflict of motives between the wish to

die and the residual wish to continue living. When a person asserts the wish to die, elapsed time alone permits life wishes to deter action on death wishes. Ambivalence is a two way street deterring self injury during acute stages, but facilitating new efforts when least expected by the observer.

Distress or loss of hope describes the emotional state leading to an increased wish to die. It is related to object loss as in depression, but also to other frustrated expectations and implicit criteria of when death is preferable.

The base rate of expected suicidal deaths and suicidal attempts per year per treatment facility can be estimated from known rates of death associated with epidemiological factors. Such an expected number of deaths or injuries provides a measure of effective prevention when compared to the actual number occurring.

The suicide prevention plan is an explicit, written treatment plan prepared with the help of the patient while in between suicide attempts. It is filed in the health records for all staff to use. A copy should be given to the patient and the family as well. Weekly review, and necessary revisions should be accomplished as often as clinical observations suggest.

Suicide prevention classes are an intervention modality where patients who are high risk are oriented towards their own suicide wishes, preferred acts of self injury, and likely consequences to self and others. The classes neutralize the patient's overinvestment in the idea of suicide with some selective destigmatization of the taboos associated with "suicidal people". High risk, meanings of death, and ambivalence are also taught, with opportunities for working thru of mixed feelings in these areas.

Letter follow up is a series of short letters sent to high risk people following a treatment where self injury was identified as a problem. It is intended as a long range, low cost-high gain extension of care for one or two years following discharge from a treatment facility.

Draw a person committing suicide is a variation on the familiar projective human figure drawing. The data elicited provides information about method, planning and previous experiences, but says nothing about if or when an act of self injury might occur.

Rorschach signs of suicide are specific to scoring and administration procedures generally taught as part of learning to use this test. A list of scores, or indices are available which together have some value in indentifying people with more wishes to die, or self injury intention.

Facts of self injury refer to the details of behavior which identify the suicidal incident; these are sometimes called the journalistic facts. The value of this information comes in

assessing lethality of any one attempt, and the progression in two or more incidents. They are also helpful in devising a suicide prevention plan.

Last things refer to the details of disposition when someone dies. Given a prolonged dying process, individuals need to make "preneed" arrangements in order to save their survivors from unnecessary distress at a time when they are most vulnerable to errors of judgment, and guilt. There is also a salutary value in reviewing the options and making choices which facilitate the quality of remaining life for the individual in a process known as coming-to-terms-with-death (Cutter, 1974, 1978).

Assessment scales are various psychological devices developed with the criteria of identifying victims likely to die from self injury behavior. The current state of knowledge does not permit a practical prediction. However, people at risk for attempting self injury can be identified effectively by the use of these same methods. A list of scales is given here.

Psychological autopsy is a review of the events, and chronology of a suicidal death, with the people who knew the victim best, and the health care team. The process generates more information than the isolated fact finding that individuals acting alone accumulate. The group process also has teaching, research, and treatment values.

Minimum lethal dose of a prescription describes the amount of a medication reported in the scientific literature that has caused one or more deaths. Such information helps the prescribing physician keep the amount of medications to less than a lethal range, when filling a prescription. This information is also helpful in emergency situations where the names and approximate amounts of ingested pills are known.

Depression refers to a clinical syndrome in which the experienced distress takes a specific pattern of symptoms, and is itself a continuing or over reaction to the actual events, or losses. Feeling bad, discouraged, or apathetic especially over a short interval and following explicit events, is not a diagnosable depression. Health professionals should look for signs of the syndrome rather than accepting at face value the explicit statement "I am depressed".

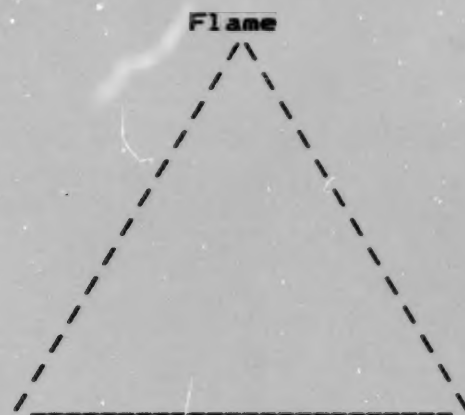
Self destructive thinking refers to images and ideas, however expressed, that convey failure, or expectations, of defeat. These thoughts shape behavior into self fulfilling prophecies and predispose the victim to acting in a self injurious way.

Models and Applications

In order for the licensed health professionals to implement any suicide prevention strategy, they need a notion of cause-effect. Two universal models exist. Most people assume one to explain or prevent suicide. The first is a group explanation such as Durkheim proposed in which the focus is on the notion of increased environmental stressors; economic depression, personal poverty, failure, pain, rejection in love affairs, life threatening illnesses, and so forth. The second model often assumed is that of personal vulnerability such as parental loss in childhood, significant frustrations early in life with arrested development in emotional-social capabilities. Freud is a prominent exponent of this logic.

The deficiencies of these prevailing models is that they do not account for, nor explain, the many people with equal stressors or vulnerabilities who do not initiate self injuries. An additional deficit is the premise that suicidal behavior is symptomatic of mental illness, distress, character disorders, or inadequate stress management (Beall, 1969; Tuckman et al 1966). Data exists which contradicts this point of view. Indeed it can be asserted that the majority of the nearly 30,000 Americans who die each year from suicide are not known to be mentally ill, depressed nor in treatment for personal distress.

The model offered here to enhance the usual ones encountered in practice is called the "Suicide Triangle". It is borrowed from fire prevention education.

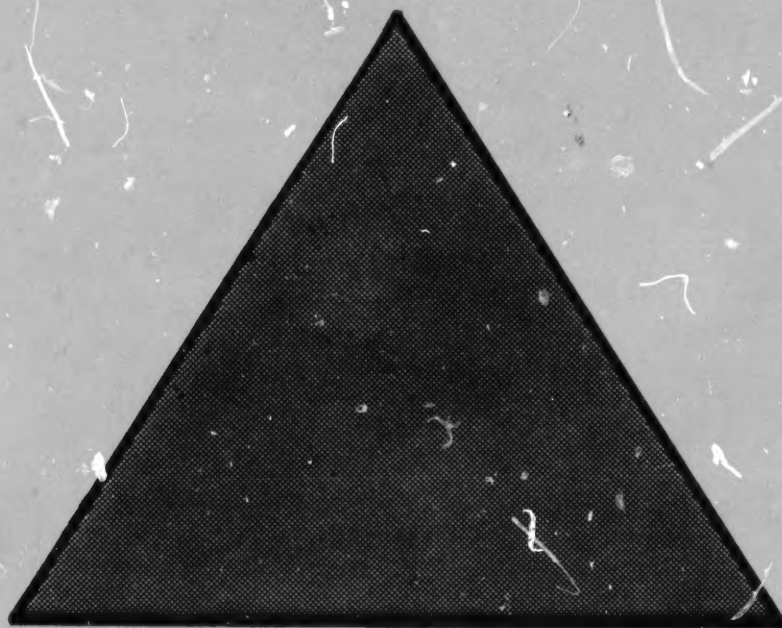


Fire cannot occur with any one aspect removed or reduced sufficiently.

Self injury behavior requires the presence of three factors which together provide a necessary and sufficient situation for self injury behavior. The relation is illustrated in the following graphic pages titled "The Suicide Prevention Triangle"

SUICIDE PREVENTION TRIANGLE

INTENSITY OF
WISH TO DIE



DEGREE OF
PLANNING

KIND AND
AMOUNT OF
DISTRESS

Necessary & Sufficient Causes of Self Injury Behavior

Self injury behavior can be deterred if one or more aspects are reduced or removed from the social situation of the high risk person. Each is a necessary, but insufficient cause by itself.

Applications of the model.

The wish to die cannot be altered directly. Like high fever, it is the result of other conditions. It is experienced when the victim perceives existence as approaching or approximating some implicit standard for when death is preferable. Under some circumstances anyone would rather cease to exist. Given such a perception, the individual is expressing a need to leave an intolerable situation or state of existence. The wish to die when observed reflects a client's desire for an alteration of existence. The health professional can intervene in terms of changing awareness; by either restructuring the definitions of issues or working with perceptions of existence.

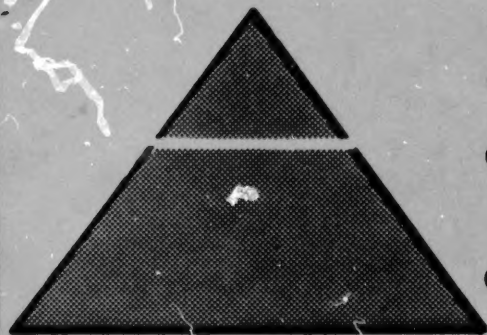
People will express the wish to die if they are given social permission by the authority figures in their environment, peers, or have some additional motives not fully recognized by either the victim or others. Regardless the licensed professional can elicit the current state of the wish to die by clinical inquiry. Simply asking, after rapport is established or as part of an ongoing clinical procedure, is sufficient.

The wish to die can come to anyone, although it is relatively rare and transitory compared to its opposite the more universal wish to live. Sometimes the two coexist and resulting conflict behavior is apparent. This is more familiar as ambivalence.

Detering action due to the wish to die has the value of providing opportunities for the wish to live to reassert itself. The wish to die can return again. The health professional needs to monitor the current state of the wish to die even after relative stability has recurred. The second graphic page illustrates the wish to die aspect.

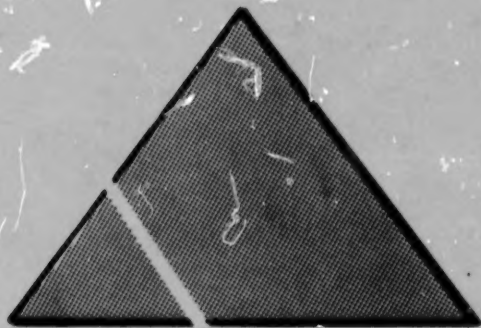
Self injury methods are over determined by character, previous history and availability (Lester, 1970). Thus one method is usually preferred over all those that are actually available. There are two exceptions to this rule of thumb. People early in the life cycle of their suicidal careers are less committed to one method. They tend to prefer two or more less lethal methods, such as wrist cutting and abuse of prescription drugs, often utilized as gestures or threats. The second exception is the behavior of more psychotic people who may act impulsively with methods of convenience which provide more lethal opportunities for self injury such as jumping or hanging. The key difference is that there is very little planning and the sheer availability of the method determines the decision to use it by these highly distressed people. Intervention with the first group permits more margin for error. The second requires more vigilance than can be maintained over extended periods of time. Both require priority attention for the underlying distress as the major

INTENSITY OF WISH TO DIE



- ACUTE vs CHRONIC
- AMBIVALENCE: *WISH TO LIVE OR DIE*
- SATISFACTION vs DEATH WISH

PLANNING



- PREFERRED METHOD & LETHALITY
- AVAILABILITY OF METHOD
- PREVENTION OF RESCUE
- DELIBERATE vs IMPULSIVE PLANNING
- CALLS FOR HELP ~ IMPLICIT-EXPLICIT

prevention strategy.

For the larger majority of high risk people who contribute the bulk of deaths by suicidal mode in the U.S., the methods are less random and approach compulsivity (Lester, 1970). This permits the health professional to block access to specific methods rather than the more usual suicidal precautions where access to all methods is denied. The latter creates situations that merely increase the amount of distress experienced by the potential victim while providing protection for short durations of time only. Selective blocking of a preferred method takes less effort and is less stressful for the client. It can also be imposed for longer time spans than the usual emergency approach. The third graphic page illustrates the degree of planning aspect.

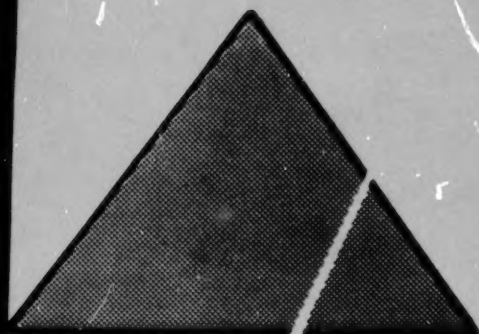
Distress and loss of hope is the most visible clinical source of motivation for self injury behavior. It is also the one for which health professionals have the most skill and experience in managing. While vulnerable individuals seem to be most prone for return of distress, over a short interval health professionals are able to do a great deal to reduce or control the experience of personal distress. Crisis intervention, tender-loving-care (TLC), problem solving, constructive listening and opportunities for catharsis, are the usual interventions when clients are identified as in need of emergency care. These are appropriate, short term responses for the prevention of suicide.

The longer range perspective is also possible and necessary. The assumption here is that in between suicide attempts, high risk people need intervention that does something for recurring distress, especially when this threatens hope (Beck et al, 1975). Usually this is accomplished thru cooperation and planning with significant others, health teams, and the device of a suicide prevention plan. The basic element is monitoring the high risk person over the first six months of post hospitalization, and the first year or two following a self injury incident. The use of suicide prevention classes after the acute phase, and letter follow ups during the one or two years post self injury represents longer term interventions that are cost effective. These yield increased support, observation, and stimulate hopefulness. The fourth graphic page illustrates the issues in managing distress.

Frequent assessment is implied in longer range interventions. The wish to die, the preferred method and the degree of distress experienced needs to be reviewed with every clinical contact and changes noted. These call for strategies that represent degrees of intervention to match the degrees of lethality and risk; rather than the all or none tactics currently in use.

The wish to die when explicit represents an acute stage calling for immediate steps to block preferred methods, and to deal with distress. The absence of the wish to die, that is the presence of the wish to live, returns the client to premorbid, but high risk state, even tho this may be moments after a self injury act.

KIND & AMOUNT OF DISTRESS



- ACUTE ANXIETY
- CHRONIC ANXIETY
- AGITATION
- DEPRESSION
- SCHIZOID PROCESS
- TOXIC REACTION TO SUBSTANCES

The health professional needs to debrief the method used for its continuing availability and lethality. It should be removed or blocked from access. The source and nature of distress are longer term issues that need to be addressed as clinical resources permit.

This overall model permits various clinical skills and procedures to be used optimally over different time frames.

Alcoholism or addiction to other substances is universal in mental health treatment settings, and facilitate self injury behavior. However, distress cannot be managed nor prevention goals achieved without first achieving abstinence. The current state of knowledge does not permit both. The longer range goal of preventing acute recurring episodes of self injury incidents is not accomplishable with continued use of substances that are addictive or cross addictive. The higher treatment priority is to achieve abstinence, and hopefully a life of positive sobriety by whatever combination of treatment strategies it is possible to provide. While exceptions can occur, and the actual suicide rate of known alcoholics with previous attempts is somewhat lower than those without alcoholic addiction, long range effective interventions are impeded by episodes of ingestion. Paradoxically, successful abstinence, at least in the first six months increases experienced distress, and requires more vigorous suicide prevention efforts for the next 12 or 24 months. The cautionary statements in the preceding paragraphs are intended to emphasize priorities of effort. The primary diagnosis is addiction rather than suicide, and the major effort should address achieving abstinence as the most optimal method of preventing self injury behavior.

Good practices for suicide prevention in any health setting.

Effective suicide prevention requires a systems approach, since one human cannot effectively control another from engaging in any willful act such as crime, drug abuse, sexual behavior, or self injury. However, some humans can introduce change, create obstacles or inspire hope. The health professional brings special resources to the task of suicide prevention in addition to their more human resources. First among these is the power and respect that their specialized knowledge, however limited, inspires in all health care clients. Such knowledge can be enhanced by thinking long range and in terms of the life cycle of high risk people coming for care. Effectively, the health professional needs to plan a suicide prevention role for everyone who participates in the care of the client. Suicide prevention is everyone's responsibility no matter what the paid assignment may be. The following list of good practices represents an array of activities that all personnel can be asked to take, without overloading or working out of classification.

1. All professionals need instructions in how to report the facts of a suicidal event. The present clinical entries in health records are incomplete, inadequately described, and lacking in operational descriptions of the facts constituting the event. This occurs partly because there is a literal breakdown of communication between those with the information and the health person who receives the news. Since most deaths or self injuries occur away from the health setting, the resulting telephone or newspaper accounts get garbled or lost in transition. However, even when the information is available health personnel fail to ask relevant questions or record significant details: who, what, where, when, how. The police investigative report is a good model of what a clinical entry should contain. This book has a Self Injury Incident Form that provides guidelines for the kind of information needed in describing any suicidal event.

2. Such information once elicited should be evaluated in order to assess lethality of methods and the degree of preference expressed in its selection. For those who survived the incident such assessment permits better planning for the prevention of the next self injury event. The rating schedules provided in this book allow the health professional to assess the kind and degree of supervision following any one self injury incident, and permits longer range planning. First, changes thru several attempts can be assessed to identify increasing lethality or overdetermination for any one method. Second, the data can be utilized in developing a suicide prevention plan, with or without the client's cooperation. Third, all of the facts can be used in identifying the degree of high risk for future self injury behavior.

A fourth and more practical value of these data come in making management decisions for a manipulative or borderline client. Not all people who exhibit a wish to die need to be hospitalized nor

supervized. The degree of lethality can differentiate those whose preferred methods of self injury provide more margin for survival than others. While all people exhibiting acute wishes to die are worthy of professional attention, the kind and degree of care is best decided by judgments based on the lethality of self injury method most likely to be used. The assessment of this lethality is facilitated by the criteria presented in this book.

3. Routine interviews with significant others, whether a self injury or death has occurred, is desirable for better health care (Rudestam, 1973). This represents a kind of psychological first aid for people who have been exposed to a trauma. Survivors have much distress, whether it be guilt, shame, anger, or anxiety that is often assuaged by the professional opportunity to review the feelings with a neutral observer. A second value is to obtain some of the clinical facts considered important for an adequate assessment of the self injury event. Where the client has survived, these interviews provide data and rapport for clinical planning to deter future self injury events. There is the long range prophylactic value that significant others, especially children, are at some greater risk for developing their own future self injury behavior following a traumatic event in their family (Paffenberger & Asnes, 1961; Greer, 1966; Bunch & Baraclough, 1971; Doorpat, 1973; Laster & Beck, 1976). More immediately, there is a tendency for survivors as well as health care professionals to reinforce the self injury behavior of clients by the attention and overreactions to death wishes, threats, and gestures. These can be minimized by appropriately orientated health professionals.

4. Psychological autopsies (Weisman & Kastenbaum, 1972; Weisman, 1974) should be organized following every suicidal event. Instituting these has the value of desensitizing all health professionals so that they can employ their best judgment free from duress guilt or anxiety. These meetings themselves are constructive in developing more information and explanations than are usually found. They also provide clinical forums for teaching health teams to work more closely together in planning for long range care as well as suicide prevention. The cost of these meetings is far less than apparent at first thought. Suicide is just as distressing to staff as it is to survivors, and much professional time is spent in trying to manage personal grief, which is much more appropriately handled in team settings. A checklist for conducting a psychological autopsy is given in this book.

5. The adoption of the preceding good practices will yield more information than is clinically usable in preventing future self injuries of the specific client. However, to accomplish this goal a suicide prevention plan must be formulated for each potential victim. This should be done with the participation of the client whenever possible, but regardless it must be accomplished at the earliest opportunity. A form is provided in this book to facilitate this goal. The basic strategy is to

identify the preferred method whether it be the most recent or the one given as likely to be chosen in the future. Next the steps that might deter or block access to it should be specified. In identifying these it is important to permit primary process logic as perceived or expressed by the client. These have the value of patient involvement and credibility. The plan adopted should meet some professional judgment of improved prevention while retaining as much of the client's feelings as possible. Such a plan can be adapted to a quasi contract where the client agrees not to act until calling the professional. However, the clinician should be cautioned to think in terms of limited time spans; hours and days rather than weeks. Suicide prevention plans should be reviewed frequently, but especially at clinical choice points such as discharge planning or treatment changes.

6. Exit interviewing should be explicit planning opportunities for each person as some phase of health care is completed. Whether inpatient discharge or outpatient followup. It is well documented that the first 3-6 months post hospital is the period of greatest risk for clients with prior self injury histories (Resnik & Lettieri, 1974). People with one or more previous incidents of self injury are considered high risk for the rest of their life. The exit interview can identify the factors associated with degree of risk and the lethality to be expected in the future based on past incidents (Farberow, 1981). In addition, such a review can formulate or update a suicide prevention plan. This would be the time to insure that coping with stress is adequate, and for building in specific suicide prevention resources such as letter follow up. Especial emphasis should be placed upon designating helpful people and insuring their availability.

7. Letter follow up has been demonstrated to be effective in reducing suicide rates of high risk people (Motto, 1978). Simply sending a friendly letter offering help and assurance, whether or not accepted, is by itself correlated with reduced death outcomes from self injury. A sample array of quarterly letters for 24 months is included in this book.

8. Suicide prevention classes for high risk people in between suicide attempts has been observed to be effective as strategy (Cutter, 1977). The content and selection criteria for conducting these group interventions are also described in this book. It should be noted that this procedure is intended for clients in between acute episodes of psychosis, depression, or the wish to die.

9. Survivors anonymous represents a self help group for high risk people in between acute episodes. It can be modeled after AA, Recovery Inc. or Patient Clubs. Where established, these represent an additional resource not otherwise available. Like any support group, there is a need for continuity of direction and leadership. These are most often provided by health professionals (Cutter, 1960; Heilig, Farberow, Litman, & Shneidman, 1968).

10. A suicide prevention committee is a resource group of professionals in any health setting organized in a multidisciplinary model to solve problems, and advise the staff of optimal procedures. Such a committee when functioning well provides a neutral group that leads psychological autopsies and gives guidelines to the whole health team. In smaller clinics or solo practice, the size and composition of the committee would necessarily be different. Local associations of peers could fill this need in the absence of a formal committee structure.

11. Annual awards for outstanding acts of suicide prevention to individuals or health teams should be made by the suicide prevention committee or appropriate alternate. Such awards can take the form of cash or recognition certificates, plaques, and publicity in the local media. While these awards can be given at any time, there is some advantage to correlating them with national suicide prevention week or annual mental health observances. The net effect is to reinforce positive action while destigmatizing the negative aspects of suicide prevention.

12. Research is always salutary in that the circumstances that are required to conduct any health study also permit more objective management of self injury data. While financial support and release time, may not always be available, individuals need encouragement to pursue research goals as a labor of love. The value here is that all self injury behavior is a negative, while all efforts to study it is a positive. The process of testing a hypothesis by data is a good suicide prevention practice in its own right since it tends to enhance the environment in which care is provided.

13. Scheduled health professional training in better suicide prevention is also a good practice. This represents continuing education and helps facilitate the professional growth needed to enhance the team capability. Aside from professional knowledge per se, the process of seeking, finding, and sharing the various audio visual material available promotes better communication and systems capability. A list of sound tapes, video cassettes, 16mm documentary movies is provided in this book. A list of books on suicide published before 1938 and after is also included. All of them have some merit as judged by the increments of knowledge they offer the whole field.

14. Every health facility and professional should compute a base rate of expected self injuries and suicidal deaths for the next year. These are computed from the epidemiological factors and the associated suicide rates for each. These are: age, sex, prior attempts, marital status, symptoms of depression, living alone and recency of discharge from health facility. Such a base rate provides a standard against which to judge the effectiveness of health care. Most facilities actually experience a far lower number of deaths than base rates would suggest. A worksheet for base rate computation is included in this book.

Suicide Outcome and Flow Chart for High Risk People

People do not suddenly decide to kill themselves. The behavior that results in self injury actions is overdetermined with respect to preferred method. The sources of distress are also non-random. The wish to die itself is secondary to an implicit criterion for when death is preferable. As this standard is approached by perception of reality, that is itself often selective, the wish to die increases until a threshold for action is passed. At this time the victim becomes ready to choose a self injury method. This in turn is influenced by previous experiences, and the meanings and values held by the victim with respect to this method. The people and circumstances in the environment facilitate or impede self injury behavior.

The licensed health professional is usually aware of these factors, but lacks a model to organize and evaluate these data. The suicide outcome and life cycle chart attempts to put all aspects of a high risk person into perspective, by looking beyond clinical episodes to the total life span of the victim.

Predisposing Factors

There are circumstances in the history of any person which increase vulnerability and predispose for high risk of suicidal deaths.

Birth. Simply being born predisposes every American to the base rate of 20 men or 7 women per year. These are derived from the national rates of suicidal death in 1979(1981). While women suicides overall are much lower, the current trend is for younger women to kill themselves more often than in the past. Those under 35 have shown a dramatically higher suicide rate in recent years (Seiden, 1969; 1981).

Significant losses. The loss of one or more parents while still a child predisposes for adult mental illness, criminality, cancer, and suicide. The way childhood bereavement is managed is important, but the correlation with adult hazards seems to be clear (Doorpat, et al 1965; Greer, 1966; Bunch & Barraclough, 1971).

Other health factors The occurrence of adult illnesses and other catastrophes, affect the stresses and aggravate vulnerabilities. However, the most dramatic influence is the occurrence of significant losses. Where identified, the health professional should not hesitate to use this information in planning suicide prevention strategy. The earlier experiences create vulnerability, while the later events exert more stress if replicating the earlier.

Role of significant other. The variety of ways family members can relate to each other is known to aggravate mental health or support positive living. Spousal relations can take the form of cooperative - supportive patterns or competitive - consuming

interactions (Shneidman, 1971) Perceived object loss, whether by death, separation or rejection, has long been recognized as the modal psychodynamic explaining the occurrence of affect disorders, namely depression; especially where observable trauma, failure, or catastrophe are not identifiable (Shneidman, 1971).

Previous suicide attempts. Prior self injury behavior is the single most reliable predictor of future suicidal attempts. History of one prior attempt yields a suicide rate of 1500 per 100,000 live attempters, per year. A history of two or more self injury incidents in the past, yields a rate of 15,000 commits per 100,000 live multiple attempters per year. These statistics do not consider the lethality of any attempts; merely their occurrence (Litman & Farberow, 1974).

Additional factors, mainly epidemiological add to the degree of risk for death per year of identified groups of people. The licensed health professional should identify those factors that increase the probability of future self injury behavior, whether epidemiological or more clinical, and utilize these in assessing or planning for prevention (Litman et al, 1974)

Stress and Vulnerability Factors

Whether the stress or vulnerability model is employed, some factors represent a combination of both in the life cycle of the high risk person.

Age and Sex. In the US, suicide rates increase with age. The older a person is, the greater the risk of death from suicide. The amount of risk in the general population is quite low. About 2 or 3 % per year of all deaths occur in a suicidal mode. The recent increase in suicide for those under 35 has altered that long standing relation. In the last decade young men are at greater risk than in the past and represent a high risk group equal to that of those over 60. Currently, women under 35 are at far greater risk than women over 65. All women are at far lesser risk than all men at every age level. These statements apply to the US only. The age phenomenon is different in other cultures.

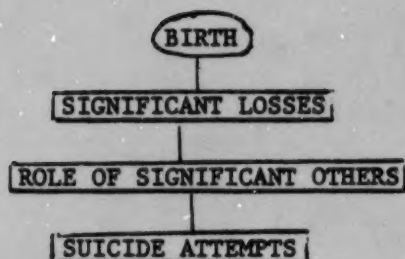
Marital status. Living alone or with someone is significant in evaluating risk of death for a suicidal mode. Males living alone have double the rate of suicide than men living with someone at ages above 60. The divorced or separated show a significantly higher suicide rate than the general population at all ages (Dominion, 1976).

Medical and surgical illnesses with associated treatments. Patients in hospitals for other than psychiatric problems show a higher rate of suicidal deaths than the general population with comparable ages. Whether the increased stress or vulnerability model is employed, the older patient, 60 plus, is at greater risk and requires more professional attention for this danger (Farberow, 1982).

Suicide Outcome & Lifecycle

Predisposing Factors

Rate per 100,00 per year



20 Men
7 Women

370 Mentally Ill

800 Depressed Patients

1500 With One Prior Attempt

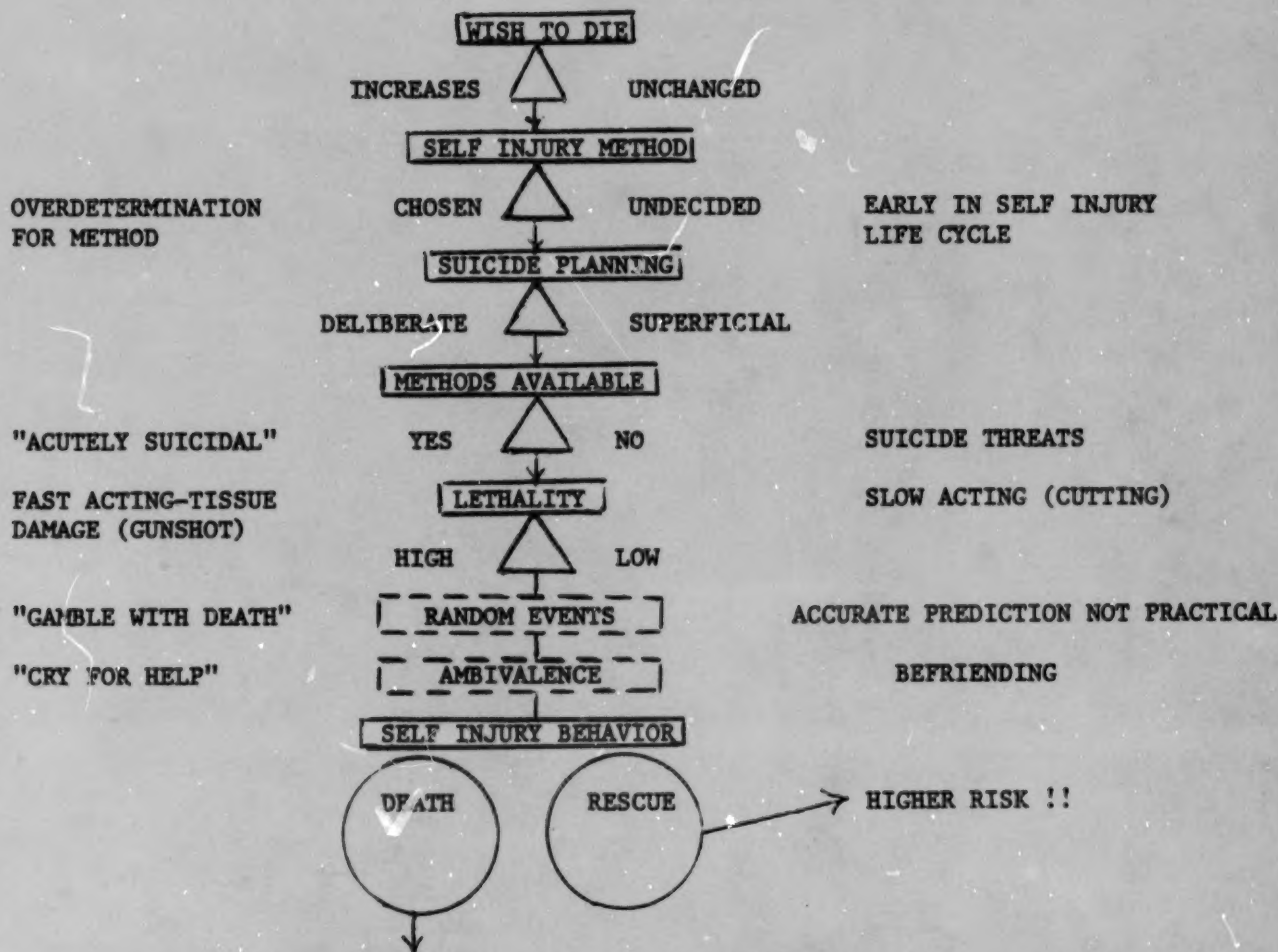
15,000 With Two Prior Attempts

Precipitating Factors

85 Medical/Surgical Patients

240 In between Spouses

10,000 Males over 60, Living Alone



These factors need to be reviewed in order for the health professional to be aware of who the high risk clients are and when their greatest vulnerability occurs. There is no such thing as zero risk. It is also ineffectual to give massive responses to moderate risks. In between, increased awareness of risk can be matched with increasing degrees of observation, support and explicit attention.

Suicide Sequence.

Wish to die. As perceptions of experiences approach some personal standard for when psychological cessation is preferable, the individual begins to wish for death with increasing intensity. Operationally, this wish is for surcease or escape rather than physical termination; current language blurs these ideas (Cutter, 1983).

Choice of self injury method. As the wish to die increases some people begin to consider the various methods of inflicting self injury. Eventually one method is preferred and effectively chosen. Implementation of this method occurs during the planning stage.

Suicide planning. Suicide planning occurs when a high risk person begins to solve the existential problems of choosing a preferred method of self injury, obtaining access to it, preventing rescue and preparing for the time and place of death (Weisman & Worden, 1974).

Methods available. Having defined a preferred method and planned its implementation. The next stage is the behavioral steps leading to access of the means (weapons, pills). The final step is the start of the self injury.

Lethality. The degree of self injury and the time needed for it to occur, measures the degree of lethality. The criteria for judging this occurs elsewhere in the workbook. The degree of lethality defines a margin of error for intervention. Fast acting methods require equally fast and intense interventions. Slower acting methods permit more opportunities for support, problem solving, and psychotherapy.

Random events and ambivalence. There is no method guaranteed to yield instant death. Death outcomes contain error factors that no one can completely eliminate nor predict. These include random events where chance factors influence the others to interrupt or rescue the victim. Conversely, these same chance factors can yield death even with minimal lethality. There is of course the ultimate error variance coming from the victim who change their minds, before during or after a self injury incident, and effectively rescue him or her self.

Self injury behavior. The observable self injury incident is always the resultant of the preceding sequence of choices, however blurred or fast these may come.

Vital outcome. Following a self injury incident, the victim may or may not survive. Death is an all or none phenomenon. Those who die are classified as suicide. Those who survive tend to be managed like all others, after a temporary crisis. This simple dichotomy distorts the process. Survivors carry an increased risk. Family or significant others never fully forget; their subsequent behavior is inherently rewarding by the overreactions to the high risk victim. The reinforcements partake of the same psychological forces that sexual orgasm, or substance abuse does in reinforcing associated behavior to occur again and again.

Where death occurs, the survivors experience some increased vulnerability to their own self injury behavior. Where the victim survives, the cycle starts over again with the same or increasing probabilities of recurrence at some time in the future.

Notes:

The High Risk Life Cycle

Early:

1. Bereavement before ages 13-15
2. Parental or surrogate suicide at any age
3. Unusual or premature death of parent after age 16
4. Parental psychopathology
5. Identified behavior or emotional problems before age 16
6. Maladjustment at school, work, or military
7. Marital problems
8. Older male, living alone
9. Under 35,
10. History of treatment for mental disorders

Middle:

11. No meaning to life
12. Alcohol, drug dependence
13. Pain, sleep, bowel, weight, problems
14. Medical compliance in long term illnesses e.g. diabetes,
15. Onset of life threatening illness; heart, cancer, stroke
16. Dependent-disatisfied behavior
17. New losses
18. Two or more serious accidents including overdose
19. Institutionalization: hospital, prison
20. Self injury behavior; low lethality, saves self

End Stage

21. Personal resources exhausted
22. Significant losses in last two years
23. Loss of hope
24. Criteria for death approached
25. Significant others more consuming or competitive
26. Aimlessness, drifting in and out of community agencies
27. Depression, acute or recent
28. Substance addiction
29. Disabled &/or unemployable
30. One or more self injuries with increasing lethality
31. Preferred method identifiable
32. Has plan with method available

The presence of these characteristics helps to place the client in some perspective with respect to urgency of intervention. If the majority of these identifiable conditions are in the end stage, the health professional has less margin of time for planning intervention strategies, and must mobilize these with more extremes of effort.

A S S E S S M E N T



High Risk People in the U.S. 1979
Data from The Statistical Abstract of the US 1981

People at greater risk for a suicidal death than the general population in the United States can be considered high risk. This implies that their usual, preclinical status is much like that of any public health disease. Some people are considered high risk for heart disease others for cancer or stroke. Epidemiological factors are used to identify the degree of risk in all of these medical outcomes. The same is possible for probabilities of death by self injury.

This chart uses the rate of suicidal death each year to establish probabilities for each epidemiological factor indicated. These are age, sex, prior mental illness, prior suicide attempts, living alone, alcoholism and recency of hospital discharge. Such information can be used by the health professional as background guide lines when making clinical or management decisions such as readiness for discharge, or frequency of clinic visits. For example followup visits after hospitalization should be tapered over a six month interval from daily to weekly to monthly to bimonthly. The first year requires regular contact whether by weekly group therapy or monthly letters.

The approximate column is a mnemonic device to help the reader remember the increasing risk levels with changing factors. All ratios are one death to the given number of live people per year. All data is male except where female is indicated.

CRITERIA	US APPROXIMATE	US EXACT
General Pop.Male	1:5,000	1:5650
General Pop,Female	1:15,000	1:15380
Prior mental illness	1:1,000	1:370
One Prior Attempt	1:100	1:67
Two Prior Attempts	1:10	1:7
Over 65,living alone	1:100	1:195
Above plus one attempt	1:10	1:19
Two prior attempts with alcoholism.		1:7

Ratio of death outcomes to live callers at LA SP Center (1974)
measured from initial call.

During first month	1:27.3	(3600/100,000)
During first six months	1:50.0	(2000/100,000)
During first year	1:71.4	(1400/100,000)
During first two years	1:95.2	(1050/100,000)
During first six years	1:181.8	(550/100,000)

Assessment Devices in Suicide Prevention by Other Authors

Despite the existence of many assessment devices and a long history of effort, the prediction of suicidal deaths is hardly beyond chance levels (Farberow & Mackinnon, 1975). The epistemology of prediction itself is really debatable, since even with a highly reliable and valid measure of death outcome, health professionals would intervene and "spoil" the predicted result (Murphey, 1974; Maris, 1968, 1969). Elsewhere (Cutter, 1977) I have suggested that it is more reliable to attempt prediction of future self injury incidents rather than death. In addition, it is appropriate to attempt assessment of the lethality of such future self injuries in order to maximize care.

The array of assessment devices available can be construed as measures of these relatively independent aspects of suicidal behavior (Beck et al, 1976). Data elicited provide opportunities for health professionals to extend some kind of intervention which will deter a death outcome by responding to lethality and likelihood of self injuries.

The following list of assessment devices are considered the most carefully developed and provide the best foundation for research programs where more precise data is needed to test hypotheses. Clinical application is more dependent on health facility and cost benefit ratios with respect to professional time needed. Where the priorities are patient management the devices and interventions suggested earlier in this book provide more optimal facilitation. None-the-less, every health professional can benefit from familiarity with the devices listed here and especially the kind of behavior implied. The complete citation and a short operational statement of what the scale appears to measure is presented next.

Beck, AT Weissman, A. Lester, D. Trexler, L. The measurement of pessimism: The Hopelessness scale. J. Consult. Clin. Psychol. 1974 42, 861-865.

-This 20 item true false scale measures ideation reflecting hopelessness that is sensitive to clinical changes in degrees of depression. The scores were factor analysed into three scales: affective, loss of motivation, and future expectations. Construct validity studies were consistent as was reliability in different samples. Norm group based on 294 hospitalized suicide attempters.

Beck, AT, Kovacs M. Weissman, A. Assessment of suicidal Intent: The scale for suicide ideation. J. Consult & Clin. Psychol., 1979, 47, 343-352. -This 19 item, objective choice test yields one total score ranging from 0-38 which appears to measure active suicidal desire, specific plans for suicide, and passive suicidal desire according to a factor analysis of the items.

Beck, RW, Morris JW & Beck, AT Cross Validation of the Suicide Intent scale. Psycholog. Reports, 1974, 34, 445-446.

-This scale consists of two parts: an eight item objective circumstances of the attempt and a seven item intention and expectations regarding the attempt. The total score ranges from 0-30. However only items 1-8 are scored for completed suicide. Completed suicides (n=194) had significantly higher ratings than attempted (N=231). Second attempters within the next 12 months (N=19) had higher ratings on the whole scale than the attempters who did not repeat. The scores do not predict suicidal death, but are useful in identifying people who are more likely to attempt another self injury.

Cull, JG & Gull, WS Manual for the Suicide Probability Scale (SPS). 1982, Los Angeles, -Western Psychological Services. This scale assesses the probability that a client belongs to a high risk population.

Farberow, NL & MacKinnon, D A Suicide Prediction Schedule for NP hospital patients. J. Nerv. Ment. Dis. 1974 158(6), 408-419.

-This 11 item objective style scale uses data from health records to arrive at a total score based on weights. Norms are given for degrees of risk for suicidal deaths. Live subjects can be considered as showing probability of future self injury behavior.

Ganzler, S. Future orientation of people with history of self injury Unpublished dissertation UCLA 1968. -Uses a semantic differential format with adjective pairs reflecting social isolation/affinity, differences between ratings of self in the future or present, which are associated with high risk for self injury incidents.

Lettieri, D.J. Suicidal Death Prediction Scales in Beck, Resnik, & Lettieri (eds) The prediction of Suicide. Bowie, Charles Press. 1974. -Four objective scales for sex and age groups, with long and short forms based upon telephone evaluation of a caller who acknowledges suicidal intention. These are not intended for those who deny suicidal intent. Clinically, the caller can be construed as likely to have more self injury incidents.

Tuckman, J & Youngman, W. A scale for assessing suicide risk in attempted suicide. J. Clin. Psychol. 1968, 24:17-19, 1968.

-This scale used items based on 17 epidemiological factors associated with higher rates of suicidal death in 3800 suicide attempters. Scoring consists of assigning one point for each factor exhibited by one patient. A total score is tabulated that places the subject in high, medium or low suicide rate population. The live subject with such a rating can be regarded also as likely to have degrees of self injury behavior.

Waisman, AD & Worden, W. Risk-Rescue Ratings in suicide assessment. In Beck, Resnik, & Lettieri (eds) The Prediction of Suicide. 1974, Bowie, Charles Press, Chapt 12. This scale uses operational measures of planning, lethality, and prevention of rescue in past attempts to arrive at weighted scores reflecting degrees of risk for future self injury events and the associated lethality.

Summary of overlapping items in common assessment scales

The scales described earlier tap common behaviors even tho worded differently. The author tabulated the overlapping items by defining the categories listed next. The intent was to provide some minimal operational statements. Futher definitions exist in the terms section of this workbook.

DISTRESS describes the behavior that implies insufficient stress management, agitation, or manifest anxiety.

ACT describes self injury behavior including degree of lethality apparent.

PLAN items refer to efforts for arranging a self injury event, and the amount of time or effort expended to achieve this.

RESCUE items describe the efforts to prevent others from interrupting a self injury action.

RISK LEVEL items give the epidemiological probability of death in the next year from a self injury.

RESOURCES, SOCIAL items indicate the lack of available resources, which tend to increase stress precipitating self injury behavior.

VULNERABILITY, PSYCHOLOGICAL describes items of pre existing attitudes that predispose the victim to more self injury behavior.

NOTES;

Description	Lettieri Scales				Sum
	Old Male	Young Male	Old Female	Young Female	
Distress	4	3	1	3	11
Wish	0	1	1	0	2
Act	0	0	1	1	2
Plan	0	0	0	0	0
Rescue	0	0	0	0	0
Risk level	1	2	4	1	8
Resource/Soc	5	2	1	1	9
Vulnerability	3	1	2	2	8
Total items	13	9	10	8	40

Description	Farberow & Mackinnon	Beck et al	Weisman & Worden	Tuckman & Youngman	Sum
Distress	6	0	0	0	6
Wish	0	0	0	1	1
Act	0	0	5	1	6
Plan	0	3	0	0	3
Rescue	0	3	5	2	10
Risk Level	2	0	0	7	9
Resource/soc	1	2	0	5	8
Vulnerability	2	0	0	1	3
Total items	11	8	10	17	46

Resource/soc(ial) refers to money, housing, family, etc.
 Vulnerability refers to psychological factors predisposing to self injury such as early loss.

Clinical Criteria for Rating Lethality of Suicide Planning

Three aspects of self injury behavior influence the lethality of the vital outcome. These three are independent of each other and additive in yielding assessment of degrees of self damage likely to occur (Cutter, 1970). These three factors are (1) adequacy of planning; (2) effectiveness of self injury methods; (3) efforts to prevent rescue.

Each can be rated on a scale of 0 to 6 by criteria provided here. All three ratings can be summed to yield total scores ranging from zero to eighteen. Average ratings for suicide attempts among veterans was 10.0. Average ratings among veterans who killed themselves was 13.3 with significant overlap in the two populations. The two samples were both neuropsychiatric and achieved comparable ratings for prior attempts. The N for attempt sample was 30; for the commit 60.

Thus the ratings are useful in establishing the probability of serious damage in the next self injury incident, while not able to predict likelihood of death. This is consistent with the current state of knowledge in not permitting statistical prediction of death outcomes from self injuries (Mackinnon & Farberow, 1975).

The attached criteria can be rated formally as indicated above or used as guides to sharpen clinical judgment in making quick evaluations of the lethality of any given attempt; whether actual or verbalized. The formal rating assigned represents a bottom in that succeeding attempts or repeated planning tends to increase the overall lethality. The clinician should expect future self injury behavior to be more lethal than in the past.

NOTES:

Adequacy of Planning.

- 0 No Planning. No preparation apparent. Can include acknowledgement that thoughts about suicide or death were had.
- 1 Intent inferred by actions, but otherwise ambiguous. No planning apparent. The observed self injury actions occur as part of impulsive, psychotic, substance influence. Accidental features are prominent. Include lack of judgment in the absence of the above.
- 2 Implicit intent apparent by prior verbalizations. Planning is superficial; has some knowledge of method and place as demonstrated by the actual effort or plan. Opportunistic features prominent, uses methods available, immediately.
- 3 Explicit intent apparent. Some preparation in evidence as in efforts to accumulate medication, obtain a gun, but no setting of time or place.
- 4 Advanced preparation with respect to availability of method choice of place or time; not both or no information noted. Shorter interval between first thought and start of self injury action (less than one week).
- 5 More advanced preparation with respect to availability of method, place, and time. Can include "alcohol for courage". Longer interval between first thought and start of self injury action (more than one week) Include paranoid delusional states.
- 6 More evidence than in #5 of planning; is aware of movement of potential rescuers; preparation of notes, wills, insurance; elaborate efforts to obtain or construct a method. Give a lower rating if elements of impulsivity present.

NOTES:

Preferred Method of Self Injury.

- 0 Self injury simulating. No damage possible. Can include more lethal method planned, if subject changes mind before acting on it.
- 1 Inadequate or ineffectual as taken. Examples: swallowed buttons, overdose of castor oil, cutting wrists with nail file.
- 2 Low order of effectiveness such as superficial cutting of wrists, depth unspecified, pushed hand thru glass window, or banged head on wall.
- 3 Moderate effectiveness. Deeper cut on wrists, requiring stitches; jumped into deep water, can swim; ingested unknown amounts of non prescription drugs available in bathroom cabinet. None or small amounts of prescription drugs. Do not include street drugs.
- 4 Ambiguous outcomes, potentially lethal. Ingested unknown amounts of prescription pills. Takes part of own prescription but leaves some. Presence of alcohol in any detectable amount, include cross addicting prescriptions used as anti anxiety agents by patients. Turned on household gas; jumped in front of or out of a moving vehicle. Jumped in water cannot swim. Cut tendons deeply. No information and street drugs scored here.
- 5 Higher effectiveness. Cutting or stabbing at vital organs, explicit description available. Took Chloroform. Ingested known household poisons. Carbon monoxide poisoning from car exhaust. Takes all of own prescription.
- 6 Higher order of effectiveness. Irreversible method, no time for rescue; gunshot, hanging, jumping from high places, or in front of a train or other heavy vehicle; Injected toxic substance in blood vessels.

NOTES:

Efforts to Prevent Rescue.

- 0 Subject rescues self before, during, or after a self injury incident.
- 1 Subject makes the attempt in the presence of one or more others, ignores lethality of method preferred. Exclude suicide pact.
- 2 Somebody notified before, or sought out immediately after the incident, especially a medical resource.
- 3 Somebody expected momentarily. Subject is, or should be aware of this potential rescuer.
- 4 Subject makes no effort to facilitate or prevent rescue. No information scored here. Leaves rescue to chance.
- 5 Method carried out or attempted in a place where possibility of intervention is minimal. Fast acting methods that preclude intervention would be rated here. If subject is rescued it would be due to chance.
- 6 Subject takes active and elaborate measures to avoid intervention. Registers in hotel under assumed name, leaves "do not disturb" sign on door.

NOTES:

Self Injury Incident

Name _____ Date _____

Informant _____ Relation _____

Date of incident _____ Time _____

Place of incident (bathroom, etc) _____

Other persons present _____

Self injury method used _____

What became of instrument used _____

Parts of body injured _____

Substances ingested (give name, quantity, size of pills; estimate if unknown) _____

Describe prior preparations made for this self injury _____

Were prior verbalizations made about self injury? _____

Did the victim take steps to prevent rescue? What? _____

ICDA No (E950-959) _____ Suicide note: Yes _____ No _____
(attach copy of note if available)

Was person hospitalized as a consequence of this incident?
If yes give details of treatment, length of stay, name of hospital, dates, etc.

If available attach copy of law enforcement report

Give dates of prior self injury incidents, and methods used

Signature: _____

Print name and title of professional below. _____

"Draw-a-Person" Committing Suicide

The ubiquitous human figure drawing test can be adapted to assess lethality of self injury experiences or planning by the simple expedient of asking a subject to draw a suicide. The usual resistances to cooperating will be encountered, and the psychologist familiar with administering this task should utilize the usual efforts to gain cooperation. In addition, suggestions can be made to the effect that most people are familiar with the topic from the information media and can choose any example they have encountered before.

The completed drawing is reviewed as a projective test, with the premise that the subject has demonstrated a preference for the plan drawn. The data thus elicited can be evaluated for lethality much like any self injury behavior. However, these do not provide information about the if or when the subject might act.

A schema for evaluating the quality of the drawings is attached. These were developed as research tools by Cutter (1976), White (1980), and Silverman (1980). The test is useful as a non verbal approach to primary processes involved in the wish to die, or the act of self injury. It does not give direct information about the if or when of suicide, but rather the how and what. In the context of suicide prevention classes the test elicits group feelings or processes that can lead to resolution of distress and better management of self injury behavior.

Rating: Description.

- | | |
|---|--|
| 0 | Blank sheet, or unable to draw an act of self injury; even tho human figure is drawn in some recognizable way Include words only even when they suggest self injury e.g. crucifixion, lynching, smoking, drinking over-eating, etc |
| 1 | Minimal injury; drawings are vague, hard to see. Flippant or silly picture. Unrealistic methods, or death symbol even tho done with explicit detail. |
| 2 | Minimal injury; drawings are vague with injury suggested more by words written on page or attitude inferred. Change of mind also detected, before during or after drawing. |
| 3 | Fast rescue/slow injury method drawn. Swallows object, drowning with rescue indicated, "accidents on purpose", etc |
| 4 | Cuts wrists, bangs head on hard object, hurting self; but drawing not convincing or conveys a diminished lethality |

- 5 Slow injury; deep cuts, small amount of pills
- 6 Deeper cuts if shown, more pills than above, with additional severity cues suggested in drawing or observations.
- 7 Unpredictable outcome by method drawn. Pills/alcohol indicated, stabbing to torso, hypodermic to arm, jumping from high wall (ten feet), drowning.
- 8 Turns on heating gas, jumping in front of or out of a moving vehicle; jump from bridge or ledge, auto accident (not clearly suicidal).
- 9 Certain/slow: Single car accident, on purpose, stabbing at vital area (heart), car exhaust method by hose or in closed garage.
- 10 Overdose of identified substance; heroin, amphetamines, barbiturates, poisons. subject's estimates of amounts needed are above the minimal dose.
- 11 Hanging, gunshot to torso, jump in front of heavy vehicle such as train or truck,
- 12 Gunshot to head; jump from sky scraper or other tall place; injection of substances with lethality clearly indicated

Reduce above scores by the following criteria;

- (-2) figure not in the act although method drawn
- (-1) lethality of method is not convincing; figure seems alive,
- (-1/2) more than one method drawn or indicated
- (+1) severity cues, and death details present

A total score is useful in research studies. It is not intended as a predictor of suicidal death outcome. Silverman (1980) noted it was uncorrelated with risk-rescue ratings. Nor did it correlate with the wish to die. The face validity suggests lethality of planning, and degree of self injury likely. Its greater value is to facilitate a suicide prevention plan that attends to all primary process motives identified.

Notes:

The future orientation test

This assessment procedure is derived from an unpublished dissertation by Sidney Ganzler (1968). It utilizes a semantic differential like approach to evaluating three concepts in terms of adjective pairs reflecting social affiliation or isolation. The three concepts are my past, my life now, and my future. The subject checks a preference on each line between the adjective pairs. The examiner assigns a score of one to seven. The ratings for all adjective pairs are summed to yield a total score ranging from 7 to 49. The lower score reflects the affiliation needs, and the higher reflects social isolation.

Ganzler's research documented significant differences in group averages between, people in crisis, those using self injury as a coping means, and those psychiatric samples with neither. Norms are not available since his samples came from a limited social strata. The clinician can use the face validity for qualitative evaluations or to compare the individual against previous scores. Ideally local norms can be developed with a sample of 30 or more clients.

The rating sheets are attached.

The adjective pairs are:

full	empty
loved	unloved
isolated	intimate
alone	together
close	apart
helped	abandoned
lonely	accompanied
shared	unshared
accepted	rejected
uncomforted	comforted
solitary	united

Ganzler asked his subjects to rate the concepts along a seven point continuum similar in presentation to the semantic differential. The instructions shown are added by this author.

MY PAST

PLACE AN "X" IN THE SPACE THAT BEST DESCRIBES YOUR FEELING

FULL	:	:	:	:	:	:	:	: EMPTY
LOVED	:	:	:	:	:	:	:	: UNLOVED
ISOLATED	:	:	:	:	:	:	:	: INTIMATE
ALONE	:	:	:	:	:	:	:	: TOGETHER
CLOSE	:	:	:	:	:	:	:	: APART
HELPED	:	:	:	:	:	:	:	: ABANDONED
LONELY	:	:	:	:	:	:	:	: ACCOMPANIED
SHARED	:	:	:	:	:	:	:	: UNSHARED
ACCEPTED	:	:	:	:	:	:	:	: REJECTED
UNCOMFORTED	:	:	:	:	:	:	:	: COMFORTED
SOLITARY	:	:	:	:	:	:	:	: UNITED

MY PRESENT

PLACE AN "X" IN THE SPACE THAT BEST DESCRIBES YOUR FEELING

FULL	:	:	:	:	:	:	:	: EMPTY
LOVED	:	:	:	:	:	:	:	: UNLOVED
ISOLATED	:	:	:	:	:	:	:	: INTIMATE
ALONE	:	:	:	:	:	:	:	: TOGETHER
CLOSE	:	:	:	:	:	:	:	: APART
HELPED	:	:	:	:	:	:	:	: ABANDONED
LONELY	:	:	:	:	:	:	:	: ACCOMPANIED
SHARED	:	:	:	:	:	:	:	: UNSHARED
ACCEPTED	:	:	:	:	:	:	:	: REJECTED
UNCOMFORTED	:	:	:	:	:	:	:	: COMFORTED
SOLITARY	:	:	:	:	:	:	:	: UNITED

MY FUTURE

PLACE AN "X" IN THE SPACE THAT BEST DESCRIBES YOUR FEELING

FULL	:	:	:	:	:	:	:	:	EMPTY
LOVED	:	:	:	:	:	:	:	:	UNLOVED
ISOLATED	:	:	:	:	:	:	:	:	INTIMATE
ALONE	:	:	:	:	:	:	:	:	TOGETHER
CLOSE	:	:	:	:	:	:	:	:	APART
HELPED	:	:	:	:	:	:	:	:	ABANDONED
LONELY	:	:	:	:	:	:	:	:	ACCOMPANIED
SHARED	:	:	:	:	:	:	:	:	UNSHARED
ACCEPTED	:	:	:	:	:	:	:	:	REJECTED
UNCOMFORTED	:	:	:	:	:	:	:	:	COMFORTED
SOLITARY	:	:	:	:	:	:	:	:	UNITED

Rorschach Signs of Suicidal Intent and Lethality

The Rorschach identification of suicide has been hampered by the blurring of the wish to die with suicidal death outcomes. The original signs of suicide identified by Piotrowski, Hertz & others have been validated against criterion groups who died or survived self injury behavior. The dichotomous group of randomly rescued people led to confounding of different motivations and a resulting failure to replicate. However in at least one attempt where the criterion was degrees of intention, measured by lethality of method, planning and prevention of rescue (Cutter, et al 1968) more of the classic signs were replicated than in a comparison approach with dichotomies. Exner has refined these same signs and along with adding more psychometric precision, also utilized the criterion of intention as measured by "the greatest probability of producing death, and permit the least amount time for rescue."

The older signs described in the Rorschach literature, will be listed here and replications reported by Cutter et al 1968) will be indicated. The more recent list and largely additional signs reported by Exner (1978) will be listed separately since the scoring is contingent upon his system. These two lists permit the reader to be aware of the accumulated wisdom in the use of the Rorschach procedures, and to choose the list which is more appropriate to their own Rorschach.

The presence of these signs in some critical degree identify subjects who are at greater risk for more lethal self injuries over the next two years. The clinical acuteness or immediacy can be judged from qualitative processes in the protocol itself, by noting experienced distress, and fragility of resources to cope with these feelings. If these signs are related to other evaluations self injury behavior or lethality ratings better assessment as well as intervention can be offered.

Both lists require an appreciation for the degrees of the wish to die and lethality of planning as criteria, rather than the more traditional all or none, suicide non-suicide decisions.

Traditional Signs as reported by Martin, (1951), confirmed by Daston & Sackheim (1960), and extended by Sapolsky (1963) and Lindner (1950). Asterisks indicate successful replication by Cutter, Jorgensen, Farberow (1968). Percentages in brackets show level of confidence achieved in tests of significance.

1. Average initial reaction time less than 27".
2. Popular less than 3; F+% more than 60
3. CF > 0 or < 3 [*5%]
4. Sum C > 1.0 or < 3.5 [*1%]
5. M:Sum C < 1.5
6. C &/or CF first response in cards VIII-X [*10%]
7. Sum C = Sum Y [*1%]
8. FV + VF < 1.0 (vista using shading)
9. D-6 location on card VII
10. Shading & color in one response (Sapolsky, 1963)
11. Deteriorating content in card IV (Lindner, 1950) [*10%]

EXNER SIGNS (1978)

1. Popular > 8 < 3
2. EP > EA where EP = Sum FM + m + C' + Y + T
EA = Sum M + .5FC + CF + 1.5C
3. FV + VF + FD > 2 FD = something in front of, or behind a vista
4. Zd > 3.5 Organization quality
5. CF + C > FC
6. S > 3 White space responses
7. F + % < 70 F+ divided by F-
8. H < 2 Exclude (H), Hd, (Hd)
9. R < 17
10. 3R + (2) both divided by total responses; where-
R is no of reflections and (2) is the number of paired reactions.
11. Shading color responses

The Satisfaction Scale

This simple scale has high user acceptance and emphasizes the positive. The client assigns a rating of one to ten for each item. The ten scores are summed. There is an additional optional item that is simply added to the total when endorsed. The total score measures the projected degree of satisfaction that a subject expresses at the time and place of the test. Implicitly, such an endorsement reflects the subject's wish to live, and inversely the absence of satisfaction or the wish to die. Silverman (1980) has demonstrated a high correlation with lethality ratings of previous suicide attempts in his sample of 30 California felons using the risk-rescue ratings (Weisman & Worden, 1974). Average ratings on his sample were 47.3 and standard deviation of 14.5 if converted from a six item to an 11 item version reported here.

Employees at a health fair who volunteered to take this scale achieved an average score of 75.3 with a standard deviation of 11.5 for 11 men and 10 women. Nineteen male dialysis patients at the Sepulveda VA achieved an average of 75.5 with a standard deviation of 15.7

The lower satisfaction scores in the prison population is consistent with their known history of social pathology and previous attempts. In addition Silverman, also reports that the satisfaction scores correlated best with risk rescue and hopelessness.

These group scores are not intended to provide norms but merely to share previous experiences. The user can apply this scale for serial testing of a high risk person over an interval of observation where changes provide clues to alterations in the wish to live or die.

SATISFACTION SCALE

NAME; _____ DATE _____

Estimate the amount of satisfaction you have today for each of these aspects of your life, by circling a number from one to ten. One is least and ten is most.

Source of satisfaction	Least										Most
Appearance	1	2	3	4	5	6	7	8	9	10	
Eating	1	2	3	4	5	6	7	8	9	10	
Energy	1	2	3	4	5	6	7	8	9	10	
Home	1	2	3	4	5	6	7	8	9	10	
Love	1	2	3	4	5	6	7	8	9	10	
Others	1	2	3	4	5	6	7	8	9	10	
Money	1	2	3	4	5	6	7	8	9	10	
Projects	1	2	3	4	5	6	7	8	9	10	
Recreation	1	2	3	4	5	6	7	8	9	10	
Self Sufficiency	1	2	3	4	5	6	7	8	9	10	
Additional Source (specify please)	1	2	3	4	5	6	7	8	9	10	

Total Satisfaction (sum of all circled numbers) _____

The Significant Loss Checklist

Significant losses in childhood are known to predispose to adult pathology (Bunch & Baraclough, 1971; Dorpat, Jackson, Ripley, 1965; Greer, 1966). Parental bereavement before adolescence has been reported in such diverse pathologies as the various cancers, mental illness, crime or suicide. While still controversial this aspect of potential explanations for self injury behavior is worthy of continuing evaluation in every high risk subject.

Significant losses include other events besides death or separation. Losses can occur by person, body part, skill, social role, or from sentimental possessions. The significant loss survey elicits data in these areas both past and recent. The checklist was modified by Tinker (1977, Silverman (1980) and Rubenstein (1981).

The scale provided in this book is intended to survey all losses perceived as important to the subject both in the past and in more recent years. The model implied here is that early losses are predisposing with more recent ones playing a precipitating role in the sense of adding stress to a vulnerable person. By assigning ages to the losses listed, the subject projects when as well as what was important in his or her background.

The items listed can be summed to provide a total count of recalled or experienced losses. These sums lack a measure of affective impact, nor are the norms available, applicable to all patients. However, the health professional can use the responses as a measure of extent, and when seasoned with professional judgment provides a clinical sense of impact and vulnerability. In this context, it can be noted that Silverman (1980) reported a significant co-relation, between past losses and suicidal intent as measured by the risk rescue ratings.

These data help introduce more clinical predictions and can be understood by clients. Well handled, these loss identifications can lead to skillful interventions such that their negative impact can be resolved.

NOTES

SIGNIFICANT LOSS CHECKLIST

NAME _____

DATE _____ AGE _____ BIRTHDATE _____

This checklist is designed to discover the important losses that people have experienced in their lives. You are being asked to identify the ones that pertain to you. Write in your age at the time the specific loss occurred to you. Leave the line blank if it does not apply to you.

<u>Loss of person</u>	First name	Relation to you	your age then
-----------------------	------------	-----------------	---------------

1. Death	A. _____		
----------	----------	--	--

	B. _____		
--	----------	--	--

2. Separation	A. _____		
---------------	----------	--	--

	B. _____		
--	----------	--	--

<u>Body Part</u>	Describe cause	your age then
------------------	----------------	---------------

3. Vitality	_____
-------------	-------

4. Limb	_____
---------	-------

5. sense organ	_____
----------------	-------

6. Other	_____
----------	-------

Activities

7. Ability to work	_____
--------------------	-------

8. Love from family	_____
---------------------	-------

9. Self Respect	_____
-----------------	-------

10. Other	_____
-----------	-------

Possessions

11. Business/job	_____
------------------	-------

12. Home, property	_____
--------------------	-------

13. Pet	_____
---------	-------

14. Other	_____
-----------	-------

Base Rate Computation

It is possible to estimate a base rate of expected occurrence of suicidal deaths per year for any given health facility or professional, by using known rates associated with epidemiological variables. The enclosed work sheets allow the computation of an expected number per year. The age sex specific rates published in the Statistical Abstracts of the US for 1982-83 (page 77) provides the numbers used on the enclosed work sheet. Page two provides for the extrapolation of this computation to estimating the expected number of suicide attempts within the same facility.

In using the enclosed work sheet, it should be noted that each line estimates an incremental fraction of the population meeting that criteria. To minimize decimals, the computation is based on rates per 1,000,000 an increase by a factor of ten. This is corrected on line nine by dividing by 1,000,000 to obtain an absolute number of deaths per health setting per year. The estimate of attempts to commit varies from 25 (Fox, 1977) to 3 Stengel, 1964). Shneidman & Farberow (1961) estimated 8.6 in California. Farberow (1972) in his survey of attempt followup studies lists the number of suicidal deaths, attempts, and periods of observation. If the percentage given for each is reduced to annual estimates and then expressed as decimal equivalents, a ratio can be defined between both. This permits the estimate of the number of attempts from the number of commits. For the eleven studies listed, the estimates vary from 1.75 to 12.0 attempts per year for international sources. American locales did not list data on attempts. The user can substitute the best estimate available for the specific locale. When in doubt 10 is both useful and optimal. Ten is indicated on the worksheet.

Given the existence of high risk people within the population served by any health professional or setting, a number of deaths from self injury is to be expected. The estimation of this number is constructive because it provides a criterion for evaluating quality of health care. The occurrence of more or less than this base rate documents better or less than optimal care. Rather than permitting arrogance or defensiveness these data facilitate objective recognition of good quality health care or needs for improvement. This book contains model worksheets for estimating the number of expected deaths and self injury incidents per year.

Base Rate Computation: Worksheet for year: _____

Name: _____ Date _____

On each line below, find the number of patients treated for each factor. Multiply this by the first number on that same line.

1. Length of mental illness:

0-12 months. 3710 x _____ = _____

13-24 " 7420 x _____ = _____

25-36 " 11130 x _____ = _____

36+ " 11480 x _____ = _____

Sums = _____ = _____

2. Age sex specific:

Males

Females:

15-24: 204 x _____ = _____

49 _____ = _____

25-44: 244 x _____ = _____

84 _____ = _____

45-64: 239 x _____ = _____

102 _____ = _____

65+: 367 x _____ = _____

70 _____ = _____

Sums: _____ = _____ = _____

Sum of male and female increments. _____ = _____

3. Males over 65, living alone: 3670 x _____ = _____

As above, one prior attempt: 3670 x _____ = _____

4. Divorced, separated, both sexes: 2400 x _____ = _____

5. One prior attempt: 15000 x _____ = _____

Two prior attempts: 150,000 x _____ = _____

Sum of both: _____ = _____

6. Depressive symptoms current: 2000 x _____ = _____

7. Recent discharge (less than 6 mos.) 850 x _____ = _____

8. Sum of increments, line 1-7 above: _____

9. Line #8 divided by 1,000,000=no of expected deaths=_____

Worksheet for estimating total number of suicide attempts 198_____

10. Total number of expected deaths (line 9): _____

11. Multiply by 10 (ratio of attempts to commits): _____

Additional attempts due to the factors listed below:

12. Multiply sum of female increment by 10* = _____

13. Multiply sum of females under 35 by 10* = _____

14. Multiply one prior attempt increment by 10* = _____

15. Multiply two prior attempt increment by 10* = _____

16. Sum of increments in lines 12-15: _____

17. Line 16 divided by 1,000,000 _____

18. Total no of attempts (line 11 + line 17) = _____

*see introductory remarks for best estimate of local ratio.

Remarks:

Name of Person completing form

Personal criteria for when death is preferable

Everybody thinks about their own death at one time or another. Many people develop an idea of when they would rather cease to be. The following questions are intended to make clear those ideas.

Name _____ Date _____

1. Death is most nearly like:

A. a long sleep: yes _____ no _____

B. a different existence: yes _____ no _____

C. the end of me: yes _____ no _____

D. no more choices: yes _____ no _____

E. other _____

2. Under what circumstances would you prefer to be dead?

3. Have you ever thought about a way of achieving death with dignity if the above circumstances came true?

yes _____ no _____ Please describe: _____

4. Would you say goodbye or tell anyone if you knew you were going to die shortly? yes _____ no _____. Please describe.

5. Have you made arrangements for your property, disposition of your body and memorial services in the event of your death? Yes _____ No _____ Please describe.

6. If you answered no above, is there a reason? Please describe.

7. Anything else you want to say about your readiness to die?

Criteria for Hospitalization of a High Risk Person.

Increasing urgency with progression thru 10 criteria
Score yes or no.

1. Client requesting admission
2. Client expresses a wish to die verbally or by gesture
3. Client threatening to injure self
4. Has a preferred method at this time
5. Has an explicit plan to kill self
6. The details of this plan are rated as very lethal

(see clinical criteria)

7. This plan and method are available to the client
8. Client belongs to a high risk population

(see risk criteria)

9. Most resources are absent in next 24 hours:

Housing_____Food_____Money_____Friends_____

Family alienated_____Significant others absent_____

10. Psychological vulnerability present:

Significant losses before 16_____

Recent losses_____

Poor stress management_____

Narrowed alternatives in thinking_____

Firm expectation that hospital is necessary_____

Agitated depression present_____

Excessive dependency present_____

Pattern of alcohol abuse, dependence or addiction_____

Consider options next page for decisions

Decisions

- a. No action needed at this time. _____
- b. Refer to single person's temporary housing. _____
- c. Call AA with followup appointments later _____
- d. Return as soon as possible for further assessment. _____
- e. Return by appointment for ambulatory interventions. _____
- f. Attempt to elicit client's cooperation in a temporary suicide prevention plan. Attach copy. _____
- g. Attempt to implement the above plan by blocking access to preferred method. Indicate client's cooperation. _____

If above options are not implementable consider admission.
Specify recommendations for first 72 hours.

_____ Hospital support, milieu therapy, general observation

_____ Medications

_____ Develop and implement suicide prevention plan

Choose one of the following:

_____ Provide closer supervision

_____ Provide closed ward supervision only

_____ Provide one-to-one supervision for 24 hours with daily review of further need.

Action taken:

Name of admitting professional

Date of request

I N T E R V E N T I O N S



Minimal lethal doses of common prescriptions

Name of prescription Trade (generic)	Estimated minimum number for a lethal ingestion in number of tabs at common available dosage
Aspirin, (acetylsalicylate)	90/5 grains
Amytal (amobarbital)	30/50mg
Benadryl (diphenhydramine)	60/50 mg
Butisol (butabarbital)	30/30 mg
Carbital (pentobarbital +)	10/100 mg
Darvon (propoxyphene)	30/65 mg
Demerol (meperidine)	24/50 mg
Dilantin (diphenylhydantoin)	30/100 mg
Doriden (glutethimide)	16/500 mg
Dramamine (dimenhydrinate)	100/50 mg
Elavil (amitriptyline)	120/25 mg
Equanil, Miltown (meprobamate)	38/400 mg
Felsules (chloral hydrate)	20/500 mg
Librium (chlordiazepoxide)	500/10 mg
Luminal (phenobarital)	45/30 mg
Mellaril (thioridazine)	100/25 mg
Nembutal (pentobarbital)	10/100 mg
Noludar (Methypylon)	17/300 mg
Nytol, sominex (methapyrilene +)	140/25 mg
Percodan (dihydrophoxycodone)	125/4.5 mg
Placydil (ethchlorvynol)	30/500 mg
Seconal (secobarbital)	15/100 mg

Seraz (Oxazepam)	333/30 mg
Stelazine (trifluoperazine)	500/5 mg
Thorazine (chlorpromazine)	44/50 mg
Tuinal (amo/secobarbital)	15/100 mg
Valium (diazepam)	1600/5 mg
Valmid (ethinamate)	30/500 mg
Veronal Bs (barbital)	100/30 mg

Notes.

1. Minimal lethal doses were estimated from the literature and computed by assuming the victim would be a healthy male, 35 years of age weighing 150 pounds. This yields a conservative estimate since the amounts listed would be more toxic in all other people, except for heavier males.
2. When overdoses accompanied with alcohol, increase tab/strength count by 50%
3. Regular drug use, when established by history, produces tolerance levels that support reduction by 33% for estimated levels of ingestion.
4. For mixed prescriptions if 80% or more are the same or equivalent minimal lethal dose treat as if the same drug. If less than 80% choose the drug with the greatest minimal lethal dose rating and evaluate amount ingested.

Adapted from Robert Sterling-Smith. A Medical Toxicology Index, Chapter 13 page 214-220. In Beck, Resnik, & Lettieri (eds) The prediction of suicide, 1974, Bowie, Charles Press.

Suicide Prevention Plan

Clinical information that is elicited in the area of previous self injury behavior can be assessed to establish future risk of recurrence and degree of lethality to be expected. Such data can be communicated to other health care professionals and the clients themselves motivated to follow these. The health professional need only complete the form provided in this book, with the client's participation, and make copies available to everyone concerned thru the health records.

During remission, or after the acute episode of wishing to die, the client can cooperate in helping the health professional develop a suicide prevention plan. The items in this form merely elicit the relevant information. Starting with the last self injury incident, or planning, the client and the professional list those items that can impede a future plan to achieve a preferred method of self injury.

Both the plan and the impediments, will include primary process logic, and meanings that are not objectively logical, but are powerful precisely because these tap into unconscious motivations, overdetermined by earlier, probably childhood experiences.

Accumulate any and all steps that deter a preferred self injury plan. The health professional can suggest additional steps, but must make sure, that the client is comfortable with these. Final implementation depends on the client's ability to act during a crisis. The planning process should also help clarify, and rehearse the prevention steps that will deter the preferred self injury. Resource people should be listed in priority to be contacted; first, second, third, etc. If client is ambivalent, attempt to resolve reluctance, or list with qualifications.

Contracts with clients can be made by having them sign at the bottom. However, as a clinical procedure, such arrangements assume a close rapport of some minimal intensity. Under the best of circumstances, such contracts are short term, measured in hours or days. These should be renewed at least weekly in face to face contacts, or daily by telephone. Letter follow ups are a long range intervention that assume the client is not in crisis at last contact. The mailing address permits its implementation at a later date and alerts the client to expect these. See the model follow up letters in this book.

The plan should be inserted into the health record so as to alert other colleagues to support it. The client should be given a copy at the time this form is completed. Modifications should be made to improve the plan whenever the client is seen. Additional copies should be provided in case the client loses the original.

Suicide Prevention Plan for-----

Date completed; By;

Most recent attempt date;

Planning:

Method used;

Rescue:

Satisfaction score;

Loss list;

Prevention steps;

1.

2.

3.

4.

5.

6.

7.

8.

Resource people;

Rank order;

Relation;

Tel no.

1.

2.

3.

4.

Suicide prevention classes
(dates attended)Letter follow ups
(address for mailing)-----
signature of client

signature of professional

History of previous self injury incidents for _____

1st.

Date; _____ time _____ address _____

Location

(bedroom, alley, etc) _____

Planning _____

Method used _____

Rescue _____

Alcohol/substance used _____

Precipitating losses (if any) _____

2nd

Date _____ Time _____ Address _____

Location (bedroom, alley, etc) _____

Planning _____

Method used _____

Rescue _____

Alcohol/substance used _____

Precipitating losses _____

For third and fourth incidents add additional sheets as necessary.

Suicide Prevention Classes: Introduction

Any licensed health professional is qualified to lead a suicide prevention class, after preparation with the material in this section. The intervention requires knowledge of the topics described later and attention to organizing criteria in the light of the particular health facility providing the care. The following guidelines are offered to facilitate the organization of this intervention.

Classes can be open-ended for at least four sessions, or closed and offered on a monthly basis to new groups. Members can be inpatients or outpatients or in transition. Individuals can be recruited on the usual epidemiological criteria of high risk; history of previous attempts or verbalizations; single males over 60, living alone; long history of mental illness; or other professional reasons that seem appropriate criteria of high risk.

The classes are usually not suitable for people in the acute stages of the following: psychosis, depression, intoxication, or self injury behavior. If high risk people regress or become acute after the classes have begun it is appropriate to continue the sessions. The difference occurs in the quality of the relation established during the class sessions.

The major purpose of the classes is to teach high risk people the nature of self injury behavior, its consequences, for self and survivors, and to design a suicide prevention plan that the subject will be more likely to follow when a new wish to die recurs. Additional goals are better observation of current status and group opportunities to collect more assessment data.

There is nothing to prevent the health professional who is qualified from attempting group therapy for specific stress or conflict behavior identified in the context of these classes. However, this becomes an additional intervention goal.

It is usually a good practice to start each session with a five to ten minute review of the topics described in the next section. The balance of the session can be taken up with group discussion of the content or resolution of resistances to change as in group therapy.

The stated goal of the classes is to help the individuals save themselves later in the event they change their minds again and wish to die at a future date. The means by which the individuals can be assisted to protect themselves in the future is by the development of a suicide prevention plan for the unique individuals involved.

Individuals who are threatened by this class should not be coerced into attending. However, such a reaction documents a rather fragile recovery or less resources in coping with future recurrences of the wish to die.

1. There is a difference between the wish to die, the act of self injury and the vital outcome. The wish is harmless in itself, can occur to everybody at one time or another, and is in conflict with the more usual wish to live. The act of self injury expresses the wish to die and occurs quite rarely in the population at large. In the high risk individual, the isolated effort to hurt oneself receives a great deal of attention to the detriment of effective suicide prevention. The victim is ignored in between suicide attempts. The vital outcome, life or death, tends to be whimsical in the sense that highly effective self injuries are blocked by heroic or accidental interventions. Conversely, minimal efforts to injure the self and can produce lethal results due to random factors. Confusion in the minds of the victim or the rescuers tend to lump the wish, the act and the outcome into one ambiguous notion of suicide.

2. There is a further difference between the acutely suicidal person during the course of a self injury and the same person later, in between episodes. The acutely suicidal person needs and usually receives close supervision, psychotropic medications, and psychotherapy or support. Later when in remission the same person can be construed as high risk for another self injury. During this longer and more normal phase, the individual can and will cooperate with long range planning and educational efforts such as the suicide prevention classes. Information can be given, and the subject's cooperation elicited to develop a suicide prevention plan for the unique individual; one that will gain the maximum cooperation. Immediately after a suicide attempt is the period when high risk people are usually the most amenable to deterrent efforts such as described here.

3. There is a conflict between the usual wish to live and the sporadically recurring wish to die, which produces ambivalence, conflicts with respect to self injury behavior. This conflict of motives gets resolved by a temporary decision to seek death. As with all conflict behavior, any action towards one goal often elicits the opposite motives. This phenomenon permits victims to change their minds before, during, or after a self injury action. Many live effective lives for years before another self injury is observed again. Ambivalence in the victim permits others to intervene. Often overlooked is the possibility of changing one's mind where the victims save themselves by simply delaying action.

4. Death is an unknown which is usually equated with sleep or other lapses of awareness. All have in common a later reawakening, usually under relatively more benign circumstances. Most people expect to feel better after a self induced death. The implication is that they will be around somehow to enjoy the change. The victim, like most people, cannot imagine a world without himself or herself in it. This phenomenon permits a potential victim to contemplate death with some equanimity since awareness appears to go on forever. This expectation makes death seductive as a release from present distress.

5. Every victim of self injury has or soon develops a non random plan to achieve death. The victim selects a method of self injury that fits the values, and lifestyle already experienced. It is only secondarily a question of availability. Orientations to self injury methods often include an association of specific attitudes that are overdetermined by needs and prior experiences with parents, role models or significant others. Personal attitudes and values become invested in a specific self injury method or circumstance. Simple inquiry is often sufficient to link a preferred method to some personal expectations. Once externalized, this information permits the development of a unique suicide prevention plan. Concerned parties and the victim can focus their efforts on deterring the identified method rather than a generalized effort to block access to all potential weapons. Aside from the improvement in efficiency of prevention efforts, the victim is able to continue with a better quality of existence even while under careful observation. A significant side effect of all this is the conversion of the patient from a potential problem to an actual rescuer.

The non random suicide plan expresses the victim's orientation to life and death. Police tend to use service guns; physicians use their medical knowledge; nurses medications; men use more violent while women use less disfiguring methods; some blacks provoke their own murder in a fight. Early self injury behavior represents a rehearsal for the final method. Trial and error helps the victim to arrive at the preferred method of self injury. In the course of such rehearsals many victims will discuss death, suicide and various methods in an effort to select and achieve an appropriate frame of mind for the eventual self injury act. Such a process is not planned, but occurs at a minimal level of awareness. When a final plan is activated, the victim will perceive this course as a freely chosen rational decision.

6. No one is neutral to the death of another, especially an intimate. Even the loss of casual associates, as in fellow patients, has significant impact. These consequences grow more intense when the death is the result of self injury. While all losses are bearable, the survivor pays an emotional price, however delayed or obscured. This is more easily apparent with children. The younger the child at the time of a parent's death the greater the likelihood of consequences in the form of adult medical, or psychological pathology. When the feelings surrounding this death are exaggerated by suicide, the survivors receive a more violent shove towards their own vulnerability, which in later years is more likely to be activated by similar precipitating events. Survivors are vulnerable to guilt, regret, and grief over their lifetime as a reaction to the suicide of a significant other. They become new victims vulnerable to mixed feelings about living and dying.

Suggestions for the Psychological Autopsy

The traditional medical pathological conference was adapted by Shneidman and colleagues in the early fifties (1961) to evaluate ambiguous modes of death reviewed by the LA Coroner's office. There is no one way to conduct an autopsy nor is it merely a collection of elicited facts. The psychological autopsy when carried out appropriately, is really a human process where health professionals, attempt to identify the motives, life style and feelings of the patients by reviewing their own observations including private feelings towards the patient.

These data become available when health care teams seek to find an explanation for self injury behavior in a client in a context of professional observations, reviews, and of searching for one or more consensuses. In this process, new facts are created coming, from participants who have accumulated attitudes based on client's behavior. In the course of reviewing victim activities one or more present begin to express these collective attitudes. Such themes become diagnostic of victim life styles, problem solving, and intentions to die.

The user of this guide line should be aware that there are levels of observation possible and that information or attitudes surfacing in the conference will have different values depending upon what source it is perceived to rise from. These levels of observation are:

1. The facts of death, or self injury
2. The chronology of these facts
3. Inferred motivations by the observers
4. Reactions of victim associates to the above
5. Collective themes observed in survivors or assembled staff

There is no set way to conduct the autopsy nor listing of facts to be obtained. It is rather a process, in which the whole is greater than the sum of its parts or the isolated facts elicited.

The list attached is simply a guide to starting the process, which will procede at its own pace and in directions never quite predictable. The guide is intended to help the chairperson keep some perspective on the events. There is no substitute for professional judgment and collegial review of ambiguous outcomes.

In addition, the facilitators should be aware that participants are experiencing a loss which varies in degree for each member of the staff, wether present or not. They will each be utilizing their own unique methods of managing these feelings. The person providing leadership to the autopsy conference needs to allow each person present sufficient psychological space to accomplish personal resolutions of grief reactions.

Guide to the Psychological Autopsy

-Prepare members for the process of reviewing a clients death.

-Elicit the facts of this death.

Describe the self injury incident: what happened, who was involved, where did it occur, when was behavior noticed, how did the self injury occur. Save "why" questions until information is elicited.

-Establish the chronology of these facts, organized from remote to time of injury. Simply list information as obtained but place in a chronological framework. Include any behavior that may seem relevant. Look for all confirmed movements in the last days.

-Note behaviors and verbalizations contributed by staff members that are not part of the previous health records.

-Attempt to infer motives for the following;

1. Wish to die, extent and duration of the wish
2. Lethality of self injury methods and amount of planning.
3. Meaning of death to the victim
4. Perception of victim's existence, especially its quality by significant others
5. Consequences of death for these others

-Reactions of others to victim death (include staff)

1. pre self injury attitudes
2. Post self injury reactions
3. Reactions "off" the record
4. Reactions in meetings

-Collective themes observed in meeting especially in controversies about the victim.

NB: The psychological autopsy should be separate from any medico-legal investigation. The chairperson should attempt to provide a non judgmental and supportive atmosphere.

Letter Follow Up after discharge from active treatment.

These model letters are to be sent at least quarterly to clients identified as high risk for a future self injury incident. These can be sent regardless of response to past interventions, and have been demonstrated to be of some value in reducing subsequent suicide rates (Motto et al. 1978).

The sender should be known personally to the client. Ideally it should be the main therapist or the case manager. Often this is not possible especially when clients have made a negative transference to this person. Clearly it helps to have some one signing the letter who is known and for whom the feelings are at least neutral if not totally positive. The letters can be prepared by clerks or workstudy students, and signed by the preferred person; if possible some handwritten notes are always more personal. These can be incorporated into the model letters contained in this book.

Wordprocessing letters can be used, if there is no attempt to deceive, and seasoned with sensitivity to the individual receiving the letter. Some respond to humor, some to frankness, and others to personally written notes.

In the last analysis it is better to send a letter than to do nothing during the follow up period. An optional note for word processing letters to be included in the first letter if deemed appropriate is illustrated next.

These letters are prepared by our staff and produced by our word processing equipment. Each one is reviewed and signed by the person responsible for your continuing care, who may add some more personal remarks as the occasion arises.

Dear Mr Smith,

We hope everything continues to go well for you since we talked three months ago. We know you prefer to manage your own affairs and respect your decision to do so. This note and the ones that will follow, are intended to encourage you in this choice, and your decision to go on with your life. We also want to assure you of our continuing availability should you need our assistance.

Sincerely,

the staff.

Dear Mr Smith,

Just another note to wish you well and assure you of our continuing availability should you want our assistance. We assume you are doing fine these last six months.

Sincerely,

the staff.

Dear Mr Smith

Its been nine months since we talked to you last. We wish you well in your efforts to manage your own affairs and are still available if anything comes up where you want our assistance.

Sincerely,

the staff

Dear Mr Smith,

We are pleased to remind you that it has been 12 months since we saw you last. We assume you have been able to manage your affairs without help from us. We will continue these notes to let you know we are cheering for you, and that we are still available should anything change.

Sincerely,

The staff

Dear Mr Smith,

It has been 18 months since our last meeting. We are pleased to think you are getting along fine by your own efforts. Let us hear from you if you can drop us a card. Otherwise we are still cheering for your continued success.

Sincerely,

the staff

Dear Mr Smith,

Congratulations! Its been two years since we had our last meeting, and you are clearly managing on your own. This is the last note scheduled, but we would be glad to continue you them if you would let us know of your interest.

Sincerely,

The staff.

Degrees of observation for degrees of suicidal risk

Clinical management of patients considered acute can be provided on the basis of the degree of apparent intention to die rather than on an all-or-none basis in which one-to-one supervision is the only recourse. The following steps represent increasing degrees of staff supervision for increasing degrees of risk to the patient. The criteria for making these evaluations and assessments are provided elsewhere in this book. Here suggestions will be provided for behavioral management.

RISK LEVEL 1. Close observation, more than is usually practiced for routine care.

- a) restrict to unit
- b) wear pajamas or special clothing
- c) frequent contacts with personnel, more than once per hour
- d) assigned bed near staff office
- e) strict implementation of existing security procedures, especially with respect to contraband, potential instruments, etc
- f) evaluation for changes in wish to die motives
- g) frequent assessment of preferred method and appropriate interventions.

RISK LEVEL 2. Closer observation than in #1 above

- a) visual observation by staff at all times
- b) locking unit, if not already a locked facility
- c) daily evaluations for changes in wish to die motives
- d) notify primary therapist of changes noted
- e) monitor preferred method, as needed.

RISK LEVEL 3. Closest observation

- a) one to one observation
- b) search possessions, room and body for all possible self injury instruments
- c) more than daily evaluations for changes in wish to die motives
- d) assessment of preferred method once per day, and appropriate changes in observation strategy to prevent the indicated self injury behavior.

Levels 1,2,& 3 are accumulative and represent increasing degrees of observation and intervention to match the increasing degrees of intent and kinds of methods preferred. Where the patient is actively, or continuously attempting to hurt self more extreme steps should be taken such as seclusion and restraints with hourly observation and support procedures provided by existing standards of care. As the degree of intention to die diminishes, and the acute suicidal stages begin to resolve, the levels can be reduced but with explicit evaluations, decisions, and documentations. Long term interventions should be started before the patient is returned to ordinary treatment regime.

Self Destructive Thinking Patterns

Self destructive thinking patterns facilitate depression and self injury behavior. These suggestions assume rapport and ongoing contacts for effective implementation. Self destructive thinking patterns can be recognized at several levels of observation. The most apparent would be self report with clearly labeled self devaluation content. The next level is observed behaviors that imply or have the effect of diminishing the subject. The third level is inferential, pattern type of motivations that manifest over several occasions or thru a variety of incidents.

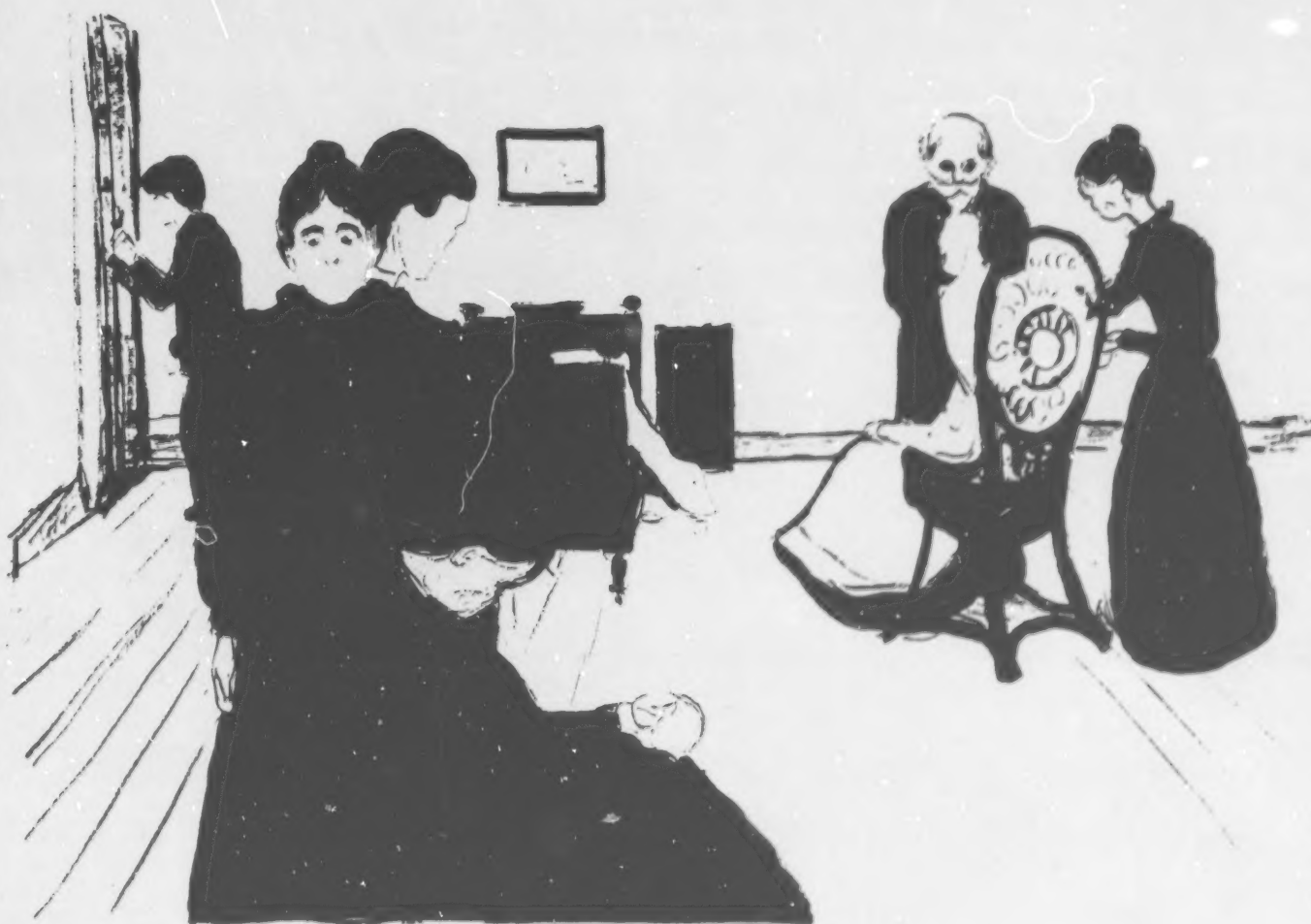
1. Self report items that overtly indicate discouragement, defeat, devaluation but without or before depressive affect. The lack of dramatic emphasis gives the appearance of passing remarks. These represent opportunities to provide equally casual support, which is all the more powerful because it is given in frequent, small unnoticed doses. These exchanges can lead to more extended interpretations, working thru, and further counteractive support.

2. Third person descriptions of self destructive thinking is possible in terms of the quality of thinking which predisposes to negative conclusions such as selective filtering out of positive and over attention to the negative. There are a variety of errors fueled by underlying distress which is channeled by these logical errors. A full description of these kinds of thinking occurs in David Burns book "Feeling Good" (1980, 40-41). This is also a good resource for cognitive behavior therapy of such self destructive processes.

3. A general pattern of both logical and behavioral self defeating behavior can also be inferred by reviewing significant defeats as selected by the patient. A variation on these is the process of self fulfilling prophecies where the subject's prevailing expectations yield events that confirm these thru a) selective attention b) provocative behavior c) misinterpretation of neutral events. The intervention with patterns of self defeat is most optimally attempted in the context of an ongoing treatment relation where the subject brings this behavior into the current situation; three examples are preferable since they document the pattern to the person.

A shorter approach is to invite the patient to state the worst expectation possible in the current (treatment) situation, and after sufficient discussion to wait for examples of this worst possibility to occur. The subject can be told "we will discuss this again". The content of these answers while unique for the person are projective and imply that these will recur in future situations that are sufficiently ambiguous or similar to prior experiences, especially with parent figures.

RESOURCES



Checklist of Computer Access Terms Knowledge Bases on Suicide.

There is a large and expanding scientific literature in suicidology. Farberow (1972) subject bibliography covers the period 1897-1970, and consists of 4744 separate entries. He has completed an update to 1980, which has not appeared in print yet. Miller (1980) provides in depth selective lists of references on 20 topics of general interest. New publications continue to appear. The reader wishing to prepare for a research project, or survey the published findings in specific areas can enter a computer search by utilizing the related terms contained here together with the word suicide or suicidology.

abortion
accident
age
aggression
alcohol
ambivalence
art, see subindex for themes in appendix of Art & The Wish to Die
artists, see subindex for names of commits in Art & The Wish to Die
attempts
assessment, see list in SUICIDE PREVENTION TRIANGLE
authors see list in SUICIDE PREVENTION TRIANGLE
body image
climate
communication
crisis
crime
death, see subindex
depression
delinquency
delusions
developmental history
dialysis
diabetes
drugs
economics
epidemics
epidemeology, see list in SUICIDE PREVENTION TRIANGLE
explanations
epilepsy
family
followup studies
films
gambling
genetics
group therapy
handwriting
high risk
homicide
hope

hospitalization
hypnosis
hysteria
identity
identical twins
insurance
lethality
loss, see significant loss SUICIDE PREVENTION TRIANGLE
lovers
lifecycle
manic depressive
manipulative
melancholic
multiple attempts
meanings
menstruation
methods, see list in SUICIDE PREVENTION TRIANGLE
military
motivation
murder
notes
occupations
potential
police
psychological autopsy, see suggestions SUICIDE PREVENTION TRIANGLE
prediction
pregnancy
prison
psychotherapy
public health ed., see list of A/V in SUICIDE PREVENTION TRIANGLE
race
rate
ratings
research
risk taking, normal
right
rituals, see list of in SUICIDE PREVENTION TRIANGLE
rural
sacrifice
self injury, see list in SUICIDE PREVENTION TRIANGLE
sex
significant others
sleep
status
suicide prevention center
suicide, see subindex of nouns
suicidal, see subindex of adjectives
suicidology, see subindex of topics
syndrome
telephone
theories
threats
time
types
typology

violence
vital outcome
volunteers
what
why
wills
wish to die &/or death wish
wish to live
youth
zero rates

Sub Indicies:

Death:

abnormal
afterlife
awareness of finality
appropriate
ars moriendi
day of the dead
denied
experience of
euthanasia
fear of
grief from
heroic
life expectancy
life span
meanings of
Memento Mori
mors ipse
murder followed by suicide
natural
normal
old age
readiness for
sacrifice
voluntary by servants

Suicide:

associations for prevention
biblical
call for help
clinical versus heroic
criteria of death preferred, see SUICIDE PREVENTION TRIANGLE
crime
history of prevention
indirect
meanings
mental illness

prevention methods
publicity
psychological journals for
psychological autopsy for
stigmatized
survivors
victims
why, problem of suicide

Suicidal:

observation for, in hospital
what, suicidal problem

Suicidology:

Acts of self injury
acute versus high risk
bibliography
crisis
epidemiology
hospitalization, see criteria in SUICIDE PREVENTION TRIANGLE
hot lines
inverse hypothesis of art and suicide, (Art & Wish to Die)
letter follow up
lethality of plan
medications
minimal lethal doses
models for explaining, see SUICIDE PREVENTION TRIANGLE
national rates
precipitating versus predisposing factors
prediction problem
rescue blocking by victim
research reviews
suicide prevention classes, see SUICIDE PREVENTION TRIANGLE
Suicide prevention plan

Notes:

Check List of Forensic Issues

In the context of self injury and suicidal death many otherwise competent health professionals manifest great fear; far more dread than is justified by the actual danger. These fears take the form of lawsuit, malpractice allegations, career damage, financial loss, or peer review deficits. The following list is provided to identify the objective criteria for when a health professional can be charged with malpractice in treatment of high risk or acutely self injurious people.

1. Standards of reasonable care in the context of suicide prevention vary with the locality in which care is provided. A recent survey of members of the American Association of Suicidology (Berman & Sandler-Cohen, 1982) documents that these standards are minimal and in need of revision. However current standards provide wide margin for practice. Good practices are described elsewhere in this workbook. Some procedures are problematic. These are premature discharge from a hospital, staff communication discrepancies, failure to deal with family requests, pattern of over prescription, insufficient health consultations, paradoxically intended remarks which can be taken by the victim as encouragement for self injury.
2. Initial and continuing staff evaluation of high risk, and lethality with appropriate response to these findings must be made and documented.
3. Previous history of self injury behavior, verbalizations, and concerns by significant others must be elicited and considered in making current treatment plans. These too must be documented.
4. Measures taken based on professional evaluations must be reasonable and appropriate in the treatment context, and efforts to follow them apparent in the documentations available.
5. Efforts to communicate with family or significant others should be apparent in the health records, family recall, or team reviews.
6. Good documentation consists of the following list of minimal items:
 - a. Treatment plan, including (suicide prevention)
 - b. Assessment of risk and lethality of method
 - c. Assignment of a case manager, or primary therapist
 - d. Specific degrees of supervision to match the degrees of risk
7. In order to win a negligence case, the plaintiff must prove the doctor owed the patient a duty, this was breached by the defendant, such breach led to harm, which was real. The courts have evolved in recent years to expecting only reasonable amount of care where it is known that a risk exists. The occurrence of a death in a health setting is not by itself evidence of malpractice.

Check List of Last Things that Document a Concern about Death

None of the items listed are by themselves an indication of a wish to die. They merely document a concern or interest which can be quite positive in its own right as in the process of Coming to Terms with Death (Cutter, 1978). However, in a health setting where the client has a background of high risk for renewed self injury, these preoccupations become an early warning which should be followed by health care evaluations and appropriate interventions if such is indicated.

Wills as formal documents

Giving or selling more personal possessions

Arranging for insurance; life, accident, mortgage, income protection

Planning for survivors usually financial but also for living arrangements or activities

Giving large gifts, or objects of great sentimental value

Arrangements for care of pets

Designating a site for dying or extended care in serious illness

Preneed arrangements or individual decisions for dealing with remains, choice of cemetery, markers, casket or memorial services.

Designating next of kin

Completing unfinished business in work, recreation, school, health setting; fulfilling expectations.

Quality of separation; saying goodbye

Writing one's own epitaph or obituary

Visible interest in art form with prominent death themes; art, music, poetry, sculpture, dance etc.

Other:

Check List of Optimal Information to Public Media

Health facilities often need to deal with the public information media who are seeking "hard news". These are often facts about special incidents involving violence. The self injury or death of a client is inherently newsworthy. The health setting has an obligation to protect the privacy of the client and its staff from intrusion into the treatment relation by all others. Some balance between the public's right to know and the client's need for confidentiality is possible. The following items of personal and public information should be considered for release. The danger of releasing too little information comes from the opportunities this creates for rumor, and jumping to conclusions. The advantage comes from the longer range goal of public confidence in the facility's credibility and quality of care.

Patient identification:

Name, age, sex, marital status, occupation, residence city, next of kin.

Self injury incident:

Time, city, location and method, degree of injury, and current health status.

Prior self injury history:

Previous incidents, mainly dates and frequency as data for evaluation of risk and lethality in present treatment planning and precautions taken before or after most recent incident.

Usual suicide prevention practice in this setting:

Usual supervision for the same degree of risk
Describe the hospital suicide prevention committee
Base rate information in general and, if available for this facility.

Usual criteria for malpractice allegations:

Suicide is considered unpredictable by current standards.
Where a risk level is identified, staff needs to provide a reasonable effort to deter, consistent with humane and locally accepted standards of rehabilitation for existing illness or stress. One to one supervision is not necessarily the best nor only option, especially for longer intervals than 24 -72 hours.

Other:

Suicide is no longer a crime in any state of the US.
Attempts are crimes in only a few states
It is a crime to facilitate another's self injury behavior in every state.

Check List of Preferred Methods of Self Injury in the US

Asphyxiation; carbon monoxide or household gas
 Bleeding from cuts or opening of blood vessels
 Burning, as in self immolation or from open fires
 Cutting or stabbing of vital organs
 Drowning
 Freezing or exposure to extreme weather
 Gunshot or explosives
 Hanging
 Ingestion of toxic substances
 Jumping from heights or in front of vehicles
 Overdose of prescriptions or addictive substances
 Provoking others into fights
 Refusing to eat, especially in a weakened condition
 Single vehicle "accidents" against abutments or trees

NOTES:

Checklist of Self Injury Rituals and Practices

Anorexia the state where a person loses their appetite sufficiently to suffer great and often life threatening weight loss. Generally, this state is associated with hysterical personality disorders in the past, but is now increasingly rationalized by feminine fashions and professional dancers. See bulimia for contrast. Contemporary American.

Bulimia a compulsive over eating thought to be a form of mental illness in which anxiety is controlled by excessive intake of anything edible. The preoccupation with certain categories of food such as sweets gives it a psychodynamic meaning. Contemporary American.

Crucifixion when preferred by early Christians to the forced choice of giving up their beliefs and faith in Christ.

Drawing blood in PreColumbian types of sacrifice and ritual self injury as by penetration thru cheeks, tongue, or penis.

Dueling in the leisure class, a European ritual common until the late 19th or early 20th century.

Falling on ones sword when faced with defeat or failure; Roman & Greek ritual.

Gambling associated with dueling in the past, but with alcohol intake, & self injury in the present American ethos.

Gladiatorial fighting with beasts or other men for exhibition during Roman times and early Christian era.

Hara Kiri a ritual Japanese form of suicide to expiate public shame, synonymous with seppuku which is restricted to the Samurai class of warriors.

Heart sacrifice Aztec ritual of cutting out the still beating heart of a volunteer by priests to appease the sun god; later included prisoners taken in battle, or arranged contests called flower wars.

Hipploytus gesture of grief first observed in Grecian history and art, but carried over to early Christian and later cultures. Also associated with self injuries as expressions of grief in mediterranean groups. Consists of clenched fist raised to forehead in a vigorous striking motion.

Ixtab Mayan goddess of hanging self. Only method deemed appropriate, and with a place reserved in the afterlife for suicides.

Je Satsu secular suicide in Japan includes all methods of self injury behavior.

Jumping into Cenotes a preColumbian ritual in which volunteers and later others were required to jump or be thrown into a limestone pit full of water while bound hand and foot. At the end of the day, they were pulled out of the water, if still alive, and were required to report their communications with the gods or the dead.

Krissing self stabbing ritual using the Balinese dagger known as the Kriss.

Normal risk taking the preoccupation with sports requiring great caution because of the high risk of injury or death. Usually involves highly technical equipment such as in scuba diving, spelunking, skiing, sport flying, and car racing. Can extend to other activities such as reckless driving, playing chicken, etc.

Oroboros snake that eats its own tail, symbol of the whole and the hole, used in alchemy; and associated with witchcraft or magic.

Running amok Maori custom of impulsively provoking others to kill by assaulting all who are encountered in the course of one last wild charge thru a public place.

Russian Roulette a largely American image and practice in which a person fires a pistol at the temple with only one bullet in a six cylinder revolver, located randomly by prior spinning. Popularized in the media and originally described in Russian novels by writers like Pushkin & Lermontov based on an idea first mentioned by Byron.

Notes:

Checklist for Manifestations of Depression by Age groups

Clinical depression in adults:

The health professional is often presented with subjects who claim depression when it is not supported by clinical data. The opposite is equally true, those who deny depression when the behavior exhibited supports that diagnosis. The following list is a systems check which reminds the observer of all the possible manifestations of clinical depression.

1. Chief Complaint;

The client will present with requests for service that are apparently appropriate to the facility. These include agencies such as school, health, employment, family service, welfare, probation, police. The presenting symptoms themselves will vary with the agency and while appropriate may be at least partially symptomatic of clinical depression. Hence the need to look at other symptom areas as listed below.

2. Emotional manifestations

- a. dejected mood
- b. negative feelings towards self
- c. reduction in sources of gratification
- d. loss of affective attachments
- e. frequent crying spells
- f. inability to react with mirth

3. Cognitive manifestations

- a. low self evaluation
- b. negative expectations
- c. self blame and criticism
- d. indecisiveness
- e. distortions of body image

4. Motivational manifestations

- a. paralysis of the will
- b. avoidance, escapist, and withdrawal wishes
- c. wish to die
- d. increased dependency

5. Vegetative and physical manifestations

- a. loss of appetite
- b. sleep disturbance
- c. loss of interest in sex
- d. fatigability
- e. motor retardation (slower motion)
- f. ruminations about past events

6. Delusions

- a. guilt and worthlessness
- b. crime and punishment
- c. nihilistic, "all is lost", "its no use"
- d. somatic
- e. poverty
- f. abandonment

Equivalent symptoms of depression in children

sad mood
self deceptive thoughts with negative self image
aggressive behavior
sleep disturbance
change in school performance
reduced socialization, withdrawal
change in attitude toward school
somatic complaints
loss of usual energy
unusual changes in appetite or weight
fear of failure
feelings of inadequacy
expects to be sad or unhappy
feelings of being unloved

Equivalent symptoms of depression in adolescents

sad mood
boredom
restlessness
substance abuse
violent behavior
skipping school
running away
preoccupation with trivia
over emotionality
sleep problems
somatic complaints
fatigue
withdrawal
poor school performance

Above checklists can overlap other syndromes. Individual items can occur in otherwise normal or general populations. The health professionals should use these checklists to support their judgment that a serious problem may be present in an otherwise routine situation. More systematic and intense efforts should be mobilized if the above checklists identify the presence of depression; i.e. more than a passing bad feeling.

NOTES:

Guide to Continuing Education Resources in Suicide Prevention

1. Sound cassettes
2. 3/4" video cassettes & film strips
3. 16 mm sound movie documentaries
4. Books published before 1938
5. Books published after 1938 (see insert)
6. Bibliographies in the field of suicide prevention

Sources listed here are intended to be all inclusive with the exceptions of material emphasizing administration of centers, philosophy, medicine, or theoretical research. The author would appreciate being advised of items overlooked or made available after the publication of this handbook.

Materials listed will show a resource center where the reader can obtain further information with respect to price, content, and ordering information for both rental or purchase. All information was compiled by abstracting from standard sources in medical libraries.

Notes:

1. Sound Cassettes

The following tapes are available from F.Cutter

Suicide prevention triangle, treatment alternatives (60 min)

Historical attitudes in western civilization (90 min)

Interview by Larry Glick, station WBZ Boston 8/27/79.

Interviews with Linnea Phillips, Station KCBX
8/19/83 & 12/2/83; public information conversations about
suicide in youth and among the elderly.

The following tapes are available from The Information Center,
6357 Lake Apopka Place, San Diego CA 92119

Marv Miller Suicide among the elderly

David Reynolds Suicide in institutions

Joseph Richman The suicidogenic family

The following items are available from the VA Central Office,
Washington DC 20420, ATTN: Office of academic affairs, Library
division of learning resource service.

Suicide and Identity. 54 minutes, 1974, audio, NL Farberow.

Suicide and suicide prevention, 12 audio cassettes, 60 minutes
each, 1972 by Bruce Danto.

Additions:

2. 3/4 Inch Video cassettes and film strips

To Keep her alive. 52 Minutes, color, Duke Univ School of Medicine, North Carolina.

Suicide. 16 minutes, color, #463 Trainex Corp, Garden Grove CA, 1976.

Suicide the Great Escape 27 minutes, Slide lecture with six slides, A K Mitchell, Albany Med. Ctr. NY 1971.

The following items are available from the source below.
Guide to AV Resources in the health care field, 1981 ed.
Published by Medical Media Publishers, 160 N Craig St,
Pittsburg, PA 15213. (412) 681-9385.

Suicide and Teenagers. 25.5 minutes. Spenco 82-560, Audio.

Suicide and the American Fairy Tale. 25.5 minutes Spenco 82-644, Audio.

Suicide: Causes & Preventions. Parts 1&2, color film-strips.

Suicide: who will cry for me. Color, 3 film strips, (293 C).

Understanding Suicide, 1979-80. Audio

additions:

3. 16 mm sound movies documentaries

Audio-visual Center, Indiana Univ, Bloomington IN (812)
(812) 337-2103

College Can Be Killing. 60 minutes, 1978, ESC 1668

The Cry for help. 32 minutes, 1963, ES 805

Suicide: It doesn't have to happen. 24 minutes, color, 1976,
CSC2661.

Suicide clinic: a cry for help. 29 minutes, 1969, CS 2148.

To be aware of death. 14 minutes, ESC 1647.

Modern talking pictures service inc(formerly National Med AV Ctr)
5000 Park St North, St Petersburg, FL 33709.

A point of return. 24 minutes, 1964, M-2057-x

Rick, an adolescent suicide. 23 minutes, 1969, M2070-x.

Suicide the unheard cry. 45 minutes, 1968, M 1810-x

The suicidal patient. 60 minutes, 1967, M 1603-x

The following items are available from: The Library Division,
Learning Resource Service of Academic Affairs. Dept of Medicine &
Surgery, VA Washington DC 20420.

Suicide in General Hospitals, 25 minutes, 1968, B/W.

Suicide prevention in the hospital. 30 minutes, 1968. B/W.

The following items are available from: Media Center, Univ Of
California, 2223 Fulton St. San Francisco, CA 94720. (415) 642-
1340.

Depression/suicide: "You can turn bad feelings into good ones"
24 minutes, color, 1976, #9614.

Suicide at 17. 18 minutes, color, 1977, #10156.

Suicide: But Jack was a good driver. 15 minutes, 1974, #9195.

4. Books Published Before 1938 on Suicide Prevention
(with some merit for the serious student of suicidology)

Achille-Delmas: La Psychologie Pathologique du Suicide, Paris 1932.

Adams, J.B. An Essay Concerning Self Murther. London, T Bennett, 1700

Alpy, Emmanuel. De la Repression du Suicide. Paris, A Rousseau, 1910.

Bayet, Albert. Le Suicide et la Morale. Paris, Libraire Felix Alcon, 1922

Blondel: Le Suicide. Strasbourg 1933

Bonser, T.O. The Right To Die. London, Free Thought Pub.Co. 1885

Brierre de Boismont, A. Du Suicide de la Folie du Suicide, Paris, G. Baillies 1865

Booth, Bramwell More Salvation Army War Dispatches (Our anti suicide Bureau, by Lt. Col Unsworth). London, Queen Victoria St. 1907.

Burton, Robert Anatomy of Melancholia. London, Chatto & Windus, (1628), 1907.

Cavan, R. Suicide. New York: Russell & Russell, 1928.

De Quincey, T. On Suicide

Donne, J. Biothanatos. 1648.

Dumas, Jean. Traite du Suicide. Amsterdam, D.J. Changuion, 1773

Dublin, L & Bunzel, B. To Be or Not To Be. 1933

Durkheim, E. Le Suicide. (1897) NY The Free Press, 1951

Des Etangs: Du Suicide politique en France. Paris 1860

Esquirol, J.Et.D. Sur le Monomanie Suicide. Paris, G. Baililere 1827

Fedden, H. R. Suicide: A social and Historical Study. London. Peter Davies. 1938.

Freud. S. Mourning and Melancholia (1917). Standard Edition, Complete Psychological Works Vol 14, (1965)

Garrison, Gaston. Le Suicide dan l'antiquite et dans les temps modernes. Paris, A. Rousseau, 1885.

Geiger, K.A. Der Selbstmord im Klassischen Altertum. Augsburg, Lit. Inst. von Huttler, 1888

Ghansamdas Malkani: Essay on Suicide. Calcuttta 1924.

Halbwachs: Le Suicide. Paris 1929

Hey, Richard. Three dissertations on the perniscious effects of gaming on dueling & Suicide. Cambridge, J Hatchard, 1785

Holmes: Is suicide Justifiable? New York 1934

Hume, D. Essay on Suicide: Collected Essays. London, Basil James Decker 1777

Masaryk.TG. Suicide as a Social Mass Phenomenon. Wien. Carl Koneyen, 1881.

Merian: Memoir Sur Le Suicide. Berlin, Royal Academy of Science & Belles Letters, 1763

Moreau de Tours: de la Contagion du suicide. Paris A Parent, 1875

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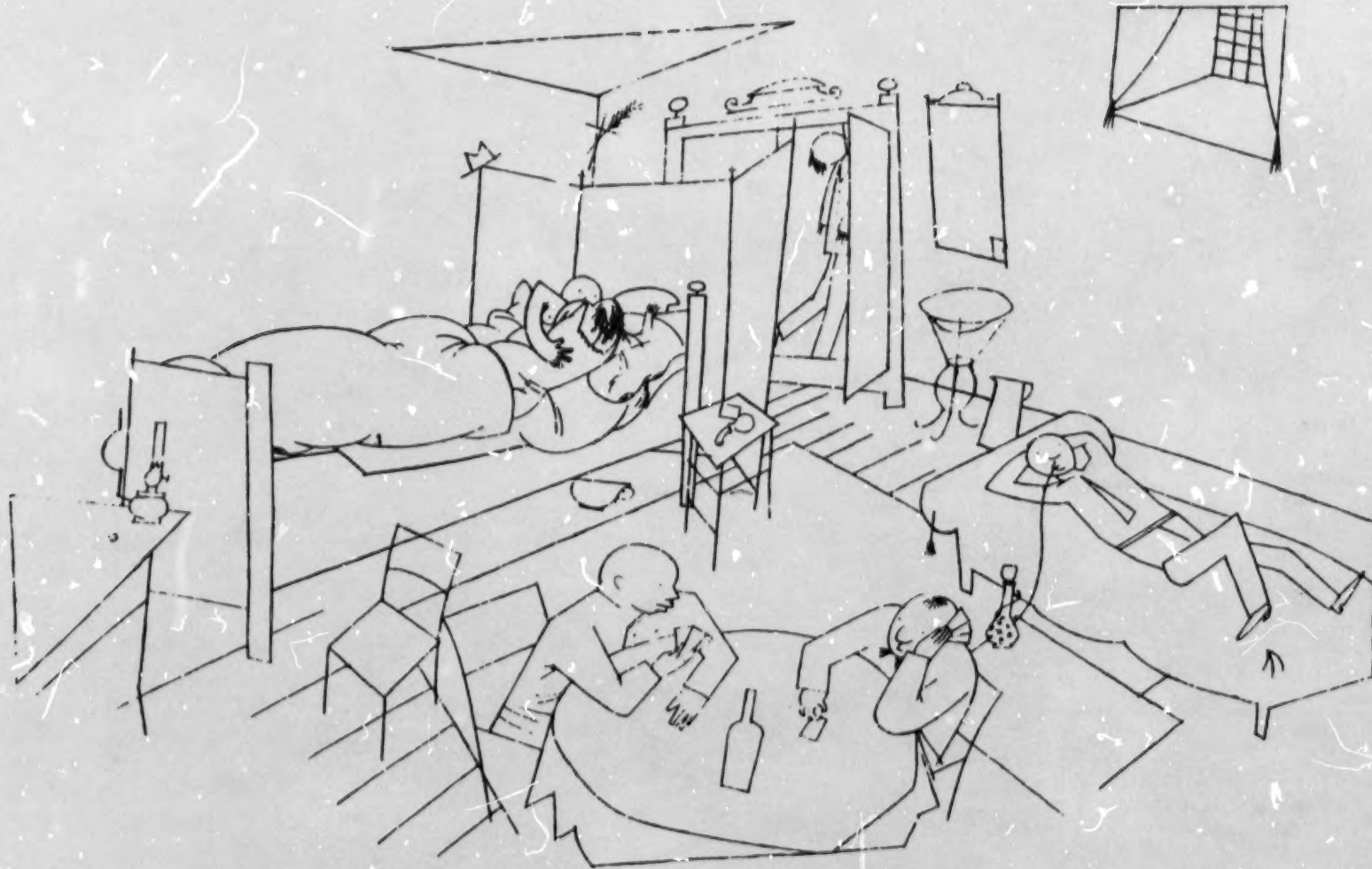
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Suicide in people under 25: Review and Suggestions

Accident and suicide in the 15-24 age class is the major causes of death because fatal diseases are relatively infrequent. Since 1954 the suicide rates for all American youths have been rising. The male rates have increased from 6.7 to 20.4 between 1954 and 1979. Note the table of male and female rates for these years (Div of Vital Health Statistics, US PHS).

College student rates have received more scientific and media attention than the young person in the general population (Farnsworth, 1966). An additional subgrouping receiving more scrutiny is the veteran, especially those from the Viet Nam era 1964-1972 (Farberow & Williams, 1982). Bruyn & Seiden (1965) computed the student suicide rate at UC Berkeley and controlled for population at risk in the state of California in 1952-1961. They concluded that suicide rates of the college population was greater. Peck and Schrut (1971) who had access to all coroner cases in LA county found that the college rate for the 1960-1966 period was 5.1 per 100,000 live students per year. This was well below the general population rate. The data from these two studies were from different times and places. These two carefully conducted investigations document the difficulty of identifying causative factors. Peck and Schrut suggest that larger universities usually located in urban centers tend to have higher rates because they attract more older men than the smaller colleges, and point towards life styles and cultural forces in addition to personal vulnerability. They minimize the roles of drugs or substance abuse as explanatory factors. Peck & Schrut offer a typical profile of the male victims they studied: "sensitive, lonely, unhappy,..who lacked close meaningful relations..."

Paffenberger, King, & Wing (1969) in a followup study of Harvard and Univ of Pennsylvania undergraduates during 1926-1959 identified predictors of later suicide in physicians with data collected as students. The average age at death was 38. The profile they constructed based on significant differences from cohorts is limited to the times and places, but may be useful to researchers seeking to recognize high risk students.

The fathers were either dead or separated, college educated and professional. The students had come from boarding schools, gave histories of smoking, using alcohol, and dropping out of college. Current complaints at the time of data collection were insomnia, worries, self consciousness and cyclothymic character

Farberow and Williams (1982) report that Viet Nam era veterans have the highest rates of all periods of service and that the under 35 age class from 1970-1980 have experienced the highest rates. Together they account for 34% of all veteran suicides in this same period. This pattern reverse the usual age distribution where the highest rates are associated with the oldest veterans. The veteran population rates tend to follow a more S shaped distribution with the highest rates at the young

and older age classes, but dipping lower in the 35-50 ages. Farberow and Williams note that the rates for the under 35 veterans are trending down starting in 1979-80.

Psychological Factors in College Suicide

Rook (1959) concluded that the higher rates among college students were associated with rigorous academic selections for Oxford and Cambridge Universities in England. This earlier report is limited by time and location, although it supports the more conventional argument that academic achievement is a major stress causing the increased suicide rates. However other factors have been identified which play an equal if not greater role in explaining rising suicide rates. Minnema and Push (1981) conclude that death anxiety is associated with preference for the right to commit and more varied justifications for choice of suicide in people who have acknowledged self injury behavior in the past. Boor (1976) correlated internal - external locus of control scores with increasing national suicide rates in the US. The younger age classes, more comparable to college age students, showed more external scores while the older classes scored higher on internal locus of control.

Lester (1967) studied Buss-Durkee test scores which measure seven different types of hostility in college students acknowledging suicidal considerations, threats, attempts and no self injury ideation or behavior. Major findings were presence of irritability and resentment score elevations in the suicidal groups. The author concludes that there is no support for the hostility to the self hypothesis. However, the elevated scores suggest a displaced or repressed type of hostility in other areas. Aside from occurrence rates 30% of college students acknowledged suicidal thoughts in the current year when queried by Craig and Senter (1972). Eleven Percent of counselees at UC Berkely came for suicidal ideation (Bruyn & Seiden, 1965). Mishara (1982) reports that college students have greater contact with victims before death by suicide and have therefore the greatest opportunities to deter peer from self injury action. His sample reported 15% prior attempts in their own histories.

Doming, Gibson, Poling and Westlake (1980) reported students attitudes toward suicide. Some of their findings: 72% feel that prevention efforts are required; 83% see suicide as a cry for help; 76% endorse the idea that everyone thinks of suicide; only 11% see suicidal behavior as normal; Many individuals endorsed commonly held misconceptions known as myths about suicide. e.g. people who talk about suicide don't commit or people who kill themselves have made a firm decision to die. Despite all the research and documentation of increasing suicidal behavior, a survey of 90 California college deans or administrators by Hendrickson and Cameron (1976) yielded a consensus that there was not a need to increase resources or deal with this problem.

Schott & Clum (1982) studied a sample of 175 students enrolled in an introductory psychology course at Virginia Poly Tech Institute. They report support for the stress-problem solving model. Students with poor problem solving and higher life stress are at greater risk for depression, hopelessness and self injury behavior. Carmen & Blaine investigated 69 Harvard and Radcliff students previous suicide attempts found these followed upon the failure of defensive and coping systems in the face of specific frustration. Important influences were loss by death or separation in the past, versus the absence of meaningful relations in the present.

Checklist of possible interventions for any school setting

1. Parents and administrators need to acknowledge that a problem exists in order to open communication about a taboo topic. A similar failure existed at the start of the drug era which occurred at the same time that increased suicide rates of the young became apparent.
2. Education is helpful for adults and youth. It should focus on:
 - a. Suicide, clarifying some of the prevalent myths and provide more description of the clinical issues;
 - b. The nature of death in current life, with emphasis on appropriate dying;
 - c. Taboos about death today;
 - d. Information about fatal disease prevalence and individual differences in achieving adjustments;
 - e. Bereavement, grief, coping with significant loss
 - f. Collateral issues, such as aging, retirement, role of behavioral medicine in facilitating coping;
3. Identify high risk students by reviewing histories, self reports or appropriate testing in areas described below.
 - a. past self injury behavior, threats of suicide, or preoccupations with the wish to die, regardless of lethality apparent.
 - b. Ideation expressed in favor of right to commit suicide, death wishes, beliefs about criteria when death is preferable. Such attitudes predispose for later self injury behavior.
 - c. Additional screening by psychological testing with specific procedures to help identify high risk people for future self injury behavior (See list of tests page 20).
4. Students identified as at greater risk need access to more support.
 - a. Non Specific counseling for identified distress at students request.
 - b. Counseling for current or past significant losses
 - c. Peer groups with other students who have volunteered for counseling focussed on suicidal thoughts & incidents.
 - d. Family systems sessions where suicide attempts or commits have occurred in the past, including grandparents, uncles or aunts.

A list of significant factors is reported by Pfeffer (1982) for family therapy with children ages 6-12, at risk of suicide: family inhibition of change; lack of generational boundaries, severity of spouse conflict, projection of inappropriate parental feelings onto children, and symbiotic parent child interaction.

Richman (1979) lists 14 points of intervention in family systems approaches to older children and adults at high risk. These are: 1. an intolerance of separation, 2. a symbiosis without empathy, 3. a fixation upon childhood patterns, 4. a fixation upon earlier social roles, 5. a closed family system, 6. a particular pattern of dealing with aggression, 7. scapegoating, 8. sadomasochistic relationships, 9. double bind relationships, 10. acting out of the bad self of the family, 11. a quality of family fragility, 12. a family depression, 13. communication disturbances, 14. an intolerance of crises.

e. Focussed suicide prevention classes in which high risk people receive training or assistance in developing their own suicide prevention plans.

d. Educational/counseling feedback sessions where testing results in general, and high risk for self injury in particular, are reviewed as ways to open up dialogue and referral are suggested by Albert, Former, and Masih, (1973).

e. Letter followup for those resistant to accepting services has been reported as effective in providing long term support that has measurable effects on later suicide rates.

5. Continuing education for staff with existing material (see list page 75-86) on a weekly basis until some level of proficiency is achieved and then monthly followups. One professional goal is to develop faculty capability of providing death education courses, and lead ongoing education for the students. However, effective suicide prevention is every employee's responsibility; conversely all employees have some degree of grief reaction to any death. Special debriefing sessions should be scheduled for all staff following an incident as part of continuing education.

6. Psychological autopsies for staff following a suicidal incident is helpful (attempts or verbal threats should be included). Everything else being equal it is appropriate to include one or more students in these conferences especially if they play a prominent role as observers or significant others. Selected autopsies can provide powerful educational material for the entire student body, especially if confidentiality issues can be resolved.

7. Peers, are in the strongest position to deter and influence other students before they reach a point of self injury. In order to mobilize these effectively, there needs to be a well defined faculty supervised, but peer led support program. This requires an ongoing weekly review of student leaders who are in resource positions such as resident counselors.

8. A suicide prevention committee is an optimal resource for developing faculty consensus, advising the administration and providing support to employees before during and after self injury incidents.

9. Help seeking attitudes need to be encouraged early in the year and during the first year of academic residence. Peer support and role modeling for these behaviors can be encouraged by orientation sessions focussed on health care and stress management co led by senior students.

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Notes:

Suicidal Elders:

Suicide in the elderly has a different meaning, in American culture, than that of the young or middle aged. In people over 60, suicide gets confounded with appropriate dying, death with dignity, and the right to commit suicide, all of which impedes suicide prevention with the elderly (Cutter, 1978). In discussing these issues, it helps to distinguish high risk from acutely self injurious people. High risk people are typically those in between suicide attempts. Rates of those over 60 have traditionally been high. In the last 10 years, the under 25 age group has become highest, but the senior rate remains at the same high rate. Acute covers all ages and implies people on the verge of action. The older group engages in more violent methods (Weiss, 1968). In the elderly the meaning and choice of method tends to be more specific.

High risk criteria for the elderly include people who live alone and are male. Patients with an early diagnosis of life threatening illness are also at greater risk. Cancer patients exhibit greater rates of suicide than the general population at risk (Marshall, et al, 1982).

A primary suicide prevention tactic for the elderly is the process of coming to terms with death (Cutter, 1978) which yields affirmation of past and present life. This also enhances a sense of integrity (Ericson, 1968) which supports continuing, while permitting a readiness to die. These concepts are elusive in clinical practice but individuals can be allowed the privilege of acting on the assumption that death is near whether next week, next month or next year; and that constructive use of remaining time can be made for those who have come to terms with the inevitability of death (Cutter, 1978).

Given the universality of death, appropriate dying is strangely esoteric. The current zeitgeist regards birth as normal and death as always due to a pathological cause. The process of "growing down" and coming to terms with death is no longer recognized as the usual experience of the elderly. These growth processes have enabled the elderly of all generations to approach death with more equanimity than happens currently (Cutter, 1978). This change is associated with the medical alterations of death starting in the post world war II era. Death to-day comes slowly occurs out of the home, and in unfamiliar places. The social process of dying itself tends to be overdetermined by expectations and habits of the victim's previous life style. As a result, the past adaptations to death and dying have been disrupted by medical interventions and changes; none of which permit a proper role for the victim in order to accomplish the "work of dying".

People in the terminal stages of any disease have unfinished business to complete. This work consists of saying goodbye, dealing with the choices of last things, helping the survivors to continue after significant loss, and expressing sentiments. An illustration of the latter is the example of Jacob on his death bed giving a blessing to his children. The biblical model assumes a knowledge that death is at hand and that the person is ready to die.

Such a process is comforting while liberating in anyone approaching the end stages of life threatening illness. The occurrence of a readiness to die is not the same as wishing for death, nor does it necessarily have to end in self injury actions. Such a readiness can facilitate patient comfort in continuing existence either with, or without, life support efforts. Readiness for death also permits the patient to maintain his or her dignity and carry it over to a point of actual death. All of which documents that the nature of self injury in the elderly is different and its appropriate prevention by health care professionals must also be different.

Health care professionals can deal with the management of self injury behavior, by starting with the meaning of current options in the broader context of the patient's history, values and relations to survivors. Such a review is inherently life affirming in that the relation works both ways: the potential survivor and the victim can share in this review and the subsequent decisions. By doing so they all facilitate optimism in the work that each must do to cope with inevitable loss.

The patient always has the right to refuse treatment if deemed competent to make that choice. Any patient can also choose to act self injuriously, regardless of rationality or competence since the act is usually underway before discovery. The resolution of the right to suicide controversy suggested for the elderly is to accept the premise that it is equally erroneous to delay death as well as to facilitate it. The recent development of societies supporting the idea of assisted death are in response to the differences noted above, and limit their scope to those with fatal diseases (Battin, 1982). The California natural death act empowers health care personnel to respond to the prior documented preferences of elderly patients with deteriorating conditions. The process of completing this document facilitates a greater sense of dignity in preparing for death. It also deters overt, impulsive, self injury behavior.

Allowing nature to take its course is not equivalent to clinical suicide but merely another life affirming choice that can come out of the existing relations and life styles of the people involved. The search for death with dignity can be supported by health professionals. The impulsive, and distress motivated impulse to engage in solitary, secretive self injury requires professional intervention.

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NOTES:

QUIZ ON KNOWLEDGE OF SUICIDE

(Circle T for true or F for false)

NAME: _____ DATE: _____

Part One.

1. Of any 10 persons who kill themselves, 8 have given some indication of their suicidal intentions.

T F

2. Individuals who attempt to injure themselves are acutely suicidal for limited time periods, only.

T F

3. Improvement following a suicidal crisis means that the self injury risk is over.

T F

4. Studies of hundreds of genuine suicide notes indicate that although the suicidal individual is extremely unhappy, he or she is not necessarily mentally ill.

T F

5. In 1979, more than 27,000 persons in the U S killed themselves and about three times that many attempted suicide.

T F

6. At one time or another, almost everyone contemplates suicide.

T F

7. Most suicidal persons who die did not have mixed feelings about living or dying.

T F

8. Almost no one commits suicide without letting someone know about their intention, at least indirectly.

T F

9. All verbal indications of suicide intent should be taken seriously, even when actual lethality is minimal.

T F

10. Altho suicide is second to accidents as the leading cause of death for teenagers, large percentages of both are facilitated by substance abuse.

T F

11. If one suspects that a person is thinking about suicide, asking about it may cause the person to commit suicide.

T F

Part Two.

12. Blocking access to a preferred method of self injury is futile since the victim can always find something else equally lethal.

T F

13. Equally high risk people can vary widely in the degree of lethality associated with their planning and method.

T F

14. In the last ten years the increasing female suicide rates means women attempt suicide as often as men in the U.S

T F

15. The self injury methods and planning used by females are more lethal than those by men

T F

16. Most people who die from self injury behavior may exhibit some element of impulsive or poorly planned actions.

T F

17. Given current knowledge there is no one necessary and sufficient cause of suicide.

T F

18. There is an "expected" number of self caused deaths each year in every treatment facility, based on high risk factors alone.

T F

19. A history of past suicidal attempts is sad but not useful in predicting future attempts.

T F

20. With enough psychological vulnerability such as mental illness, or alcoholism, or excess dependency, or significant loss, etc, it becomes more difficult to achieve total prevention of high risk people from self injury behavior.

T F

21. High risk people, especially those in treatment, will not cooperate in developing a useful suicide prevention plan which spells out steps to take and resource people to call.

T F

22. The suicidal motivations of those under 35 is different from those over 35.

T F

23. People with two or more previous suicide attempts have the same risk of death as those with one prior self injury incident.

T F

24. Most victims of suicide in the US are mentally ill.

T F

25. Most people with clinical symptoms of depression are also acutely suicidal.

T F

26. All deaths by suicide have a clinically diagnosibile depression.

T F

27. Potential victims usually take the "right" to kill themselves by simply acting on a self injury plan.

T F

28. Current malpractice and licensing laws require the health professional to attempt prevention if the victim is observed to engage in self injury behavior or planning.

T F

29. Alcohol or substance abuse facilitates self injury behavior in over half of the victims of suicide.

T F

30. Traditional suicide prevention strategies in western civilizations were based on sin, crime, and mental illness models of suicide.

T F

SCORE: _____

NUMBER CORRECT DIVIDED BY 30= PERCENT PASSED.

Nurses. NIH Pub # 82-2308 Aug 1981. US Dept of Health & Human Services.

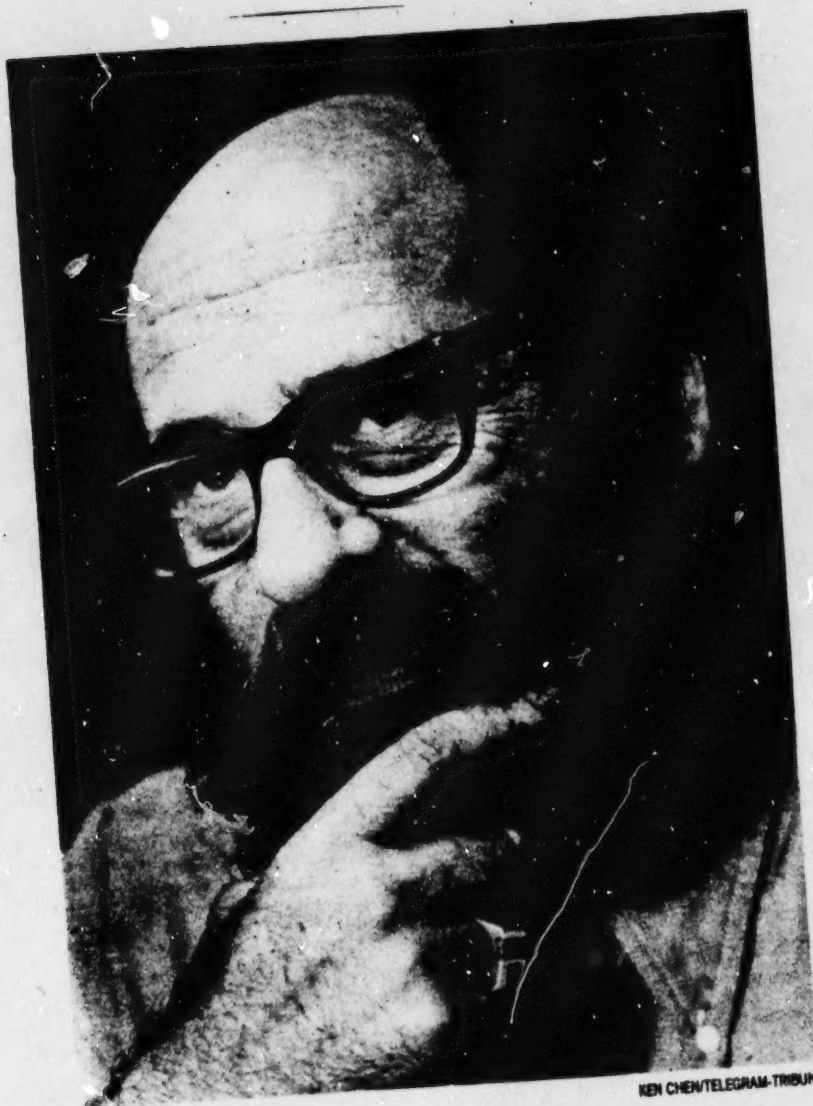
Questions 12-30 prepared by Fred Cutter, Ph.D. Based on information in The Suicide Prevention Triangle. Triangle Books Morro Bay, CA 93442 1983.

Answers to quiz on knowledge of suicide questions from Suicide Prevention Triangle Workshop.

- | | |
|-------|-------|
| 1. T | 16. T |
| 2. T | 17. T |
| 3. F | 18. T |
| 4. T | 19. F |
| 5. F | 20. T |
| 6. T | 21. F |
| 7. F | 22. T |
| 8. T | 23. F |
| 9. T | 24. F |
| 10. T | 25. F |
| 11. F | 26. F |
| 12. F | 27. T |
| 13. T | 28. T |
| 14. F | 29. T |
| 15. F | 30. T |

RAW SCORE: _____ PERCENT PASSED: _____

THE NUMBER CORRECT DIVIDED BY 30= PERCENT PASSED
(C) F Cutter 1/21/84 Quiz



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